

1 STATE OF MISSISSIPPI )  
2 ) SS:  
3 COUNTY OF JACKSON )  
4 IN THE CHANCERY COURT OF  
5 JACKSON COUNTY, MISSISSIPPI  
6 IN RE MIKE MOORE, ATTORNEY GENERAL )  
7 EX REL, STATE OF MISSISSIPPI ) Cause No.  
8 TOBACCO LITIGATION, ) 94-1429  
9

10 The deposition of KEVIN VERNER, called  
11 for examination, taken before SUSAN M. MARTINO, a  
12 Notary Public within and for the County of Cook,  
13 State of Illinois, and a Certified Shorthand  
14 Reporter, CSR No. 84-1990, of said state, at Suite  
15 3500, 77 West Wacker Drive, Chicago, Illinois, on  
16 the 22nd day of March, A.D. 1997, at 1:30 p.m.  
17  
18  
19  
20  
21  
22  
23  
24

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1        **PRÉSENT:**

2                JONES, DAY, REAVIS & POGUE,  
3                (North Point, 901 Lakeside Avenue,  
4                Cleveland, Ohio 44114), by:  
5                MR. PAUL G. CRIST,

6                                -and-

7                JONES, DAY, REAVIS & POGUE,  
8                (Metropolitan Square,  
9                1450 G Street, N.W.,  
10               Washington, D.C. 20005-2088), by:  
11               MR. GEOFFREY K. BEACH,

12                               appeared on behalf of Defendant  
13                               R.J. Reynolds Tobacco Company.

14        **ALSO PRESENT:**

15               MR. CARY DAVIDOW, Videographer.  
16  
17  
18  
19  
20  
21

22        **REPORTED BY:    SUSAN M. MARTINO, CSR. No. 84-1990.**  
23  
24

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(WHEREUPON, certain documents  
were marked Verner Deposition  
Exhibit Nos. 1 through 57, for  
identification, as of 3-22-97.)

THE VIDEOGRAPHER: We are going on the video  
record at 1:30 p.m.

My name is Cary Davidow. I'm a  
videographer in association with Wolfe & Rosenberg  
& Associates and my address is 188 West Randolph  
Street. The court reporter is Susan Martino of  
Wolfe Rosenberg & Associates.

This videotape dep of Kevin Verner is  
taking place on March 22nd, 1997 and the location  
of this deposition is 77 West Wacker Drive,  
Chicago, Illinois.

This deposition is being taken in the  
matter of In Re Mike Moore, Attorney General, Ex  
Rel State of Mississippi Tobacco Litigation, file  
No. 94-1429.

This deposition is being taken on  
behalf of the defendants. The party at whose  
instance the deposition is being recorded on an  
audiovisual recording device are the defendants.

Will counsel please announce their

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1 appearances for the record.

2 MR. CRIST: Yes. My name is Paul Crist. I'm  
3 with the law firm of Jones, Davis, Reavis & Pogue  
4 in Cleveland, Ohio, and I represent the defendant,  
5 R.J. Reynolds Tobacco Company.

6 MR. BEACH: My name is Jeffrey Beach. I'm  
7 also an attorney with the law firm of Jones, Day,  
8 Reavis & Pogue and represent R.J. Reynolds Tobacco  
9 Company.

10 THE VIDEOGRAPHER: Will the reporter swear  
11 the witness, please.

12 (WHEREUPON, the witness was duly  
13 sworn.)

14 MR. CRIST: Before we begin, Mr. Verner, this  
15 case has been noticed, as the videographer noted,  
16 in the In Re Mike Moore case, and we have  
17 pre-marked as Verner Deposition Exhibit No. 51 a  
18 copy of that notice.

19 This case has also been cross-noticed  
20 into a case entitled the State of Florida, et al.,  
21 versus the American Tobacco Company, et al., and  
22 we have marked that cross-notice of taking  
23 deposition as Verner Deposition Exhibit No. 52.

24 We have begun this deposition at 1:30

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1 with Jodie Flowers and she told me that this  
2 deposition would be going forward and that a  
3 notice of deposition for Mr. Verner which  
4 heretofore had not been provided by the State  
5 would be faxed to my attention that evening,  
6 again, that date being March 13th.

7 On March 14th, I sent a letter to Jodie  
8 Flowers at the Ness Motley law firm containing the  
9 first installment of documents to be produced to  
10 the plaintiff pursuant to the agreements between  
11 the parties concerning the documents that would be  
12 produced in connection with defense expert  
13 depositions.

14 My letter, which has been marked as  
15 Exhibit 55, contained the following language:  
16 "This will confirm that you intend to take the  
17 videotape deposition of Mr. Kevin Verner on March  
18 22nd in Chicago, Illinois, at the location  
19 indicated on the notice of deposition received  
20 March 13, 1997.

21 "As I indicated to Ms. Hoffman and  
22 previously on February 19th in a letter to Ms.  
23 Ritter, we anticipate conducting a brief  
24 videotaped direct examination of Mr. Verner

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1 following the conclusion of your deposition for  
2 use at trial. Ms. Hoffman told me that she would  
3 discuss this with you so that we can work out the  
4 necessary logistics.

5 "I am confident that appropriate  
6 arrangements can be worked out and appreciate your  
7 cooperation in that regard. Enclosed are the  
8 documents which defendants have agreed to produce  
9 in connection with the depositions of defense  
10 experts. In addition, I have two short videotapes  
11 to be produced and a few other items. These  
12 additional items are being duplicated and will be  
13 forwarded under separate cover early next week.  
14 Please do not hesitate to call if you have any  
15 questions."

16 I should note that as referenced in my  
17 letter dated the 14th, it indicates -- or I  
18 indicate in my letter that I had received a notice  
19 of deposition dated March 13th. This was based on  
20 my reliance on the statements of both Ms. Hoffman  
21 and through Ms. Hoffman Miss Flowers that in fact  
22 a notice of deposition would be delivered to me on  
23 the 13th.

24 In fact, I was out of town at the time



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1 and did not learn until the next day that that in  
2 fact did not occur.

3 I saw Miss Flowers at a deposition on  
4 March 14th and I told her that I had not yet  
5 received a notice of deposition for Kevin Verner  
6 as promised. Ms. Flowers told me that she would  
7 look into why no notice had been received.

8 On the following Monday, March 17th, I  
9 saw Ms. Flowers at another deposition and informed  
10 her that I still had not received a notice of  
11 deposition for Kevin Verner.

12 Ms. Flowers told me that Ron Motley  
13 would be taking this deposition; that it was  
14 difficult to reach him, and, as a result, she  
15 would coordinate with him to find out the status  
16 of the deposition notice and would try to get back  
17 to me. She suggested, in addition, that I might  
18 try to reach Mr. Motley through his secretary.

19 The next day, March 18th, I called  
20 Jodie Flowers at the Ness, Motley firm to find out  
21 the status of this case. I was told that Ms.  
22 Flowers was out of town. So I then called  
23 Mr. Motley. Mr. Motley was also out of town and I  
24 was then transferred to his secretary.

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1 I left her a voice mail message  
2 describing the pendency of this deposition, the  
3 fact that I -- that no notice had been received  
4 and asking that she call me or Mr. Motley call me  
5 at their earliest convenience. This call was  
6 never returned by either Mr. Motley or his  
7 secretary.

8 The following day, March 19th, I again  
9 attempted to reach Ms. Flowers to find out the  
10 status of the Verner deposition. Ms. Flowers was  
11 unavailable and I spoke with Mr. Motley's  
12 paralegal, whose name is Tammy.

13 Tammy promised to find out the status  
14 of the deposition and the status of the notice of  
15 the deposition and call me back. At approximately  
16 four p.m. that afternoon, she reported to me that  
17 she had been unable to contact Mr. Motley or Ms.  
18 Flowers; that she might receive a call from them  
19 at home and in which case she would leave a  
20 message on my voice mail.

21 Approximately three-and-a-half hours  
22 later or at 7:20 p.m. Eastern Time, I received a  
23 faxed letter from Ms. Flowers, which this letter  
24 has been marked as Verner Exhibit 56.

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1           In this letter, Ms. Flowers wrote, "I  
2 write to address your request that the defense be  
3 allowed to take an hour-long direct video  
4 deposition during the March 22nd deposition of  
5 Mr. Verner in light of the defense's position that  
6 Mr. Verner will not be brought to trial.

7           "After having opportunity to confer  
8 with other counsel for the State, we have decided  
9 we have no need to take a deposition of Mr. Verner  
10 and are thus cancelling his deposition. I would  
11 appreciate it if you would notify Mr. Verner and  
12 other defense counsel of this decision. Please do  
13 not hesitate to call should you have any  
14 questions."

15           Finally, on March 21st, I received a  
16 subsequent correspondence from Ms. Flowers  
17 following our noticing of this deposition and  
18 taking the position -- and I won't quote it for  
19 the purposes of this record -- that the deposition  
20 had not been properly noticed and on that -- for  
21 that reason they would not appear or not be able  
22 to appear.

23           I would like to make one final note for  
24 the record; that Mr. Verner was deposed in

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1 litigation against R.J. Reynolds, a case entitled  
2 Connor -- that's spell C-o-n-n-o-r -- versus R.J.  
3 Reynolds on October 2nd, 1995 on the very subject  
4 that he has been noticed as an expert in this  
5 case.

6 The law firm Ness Motley, which is of  
7 counsel of record for both the States of  
8 Mississippi and Florida, is now counsel of record  
9 in the Connor case.

10 KEVIN VERNER,  
11 called as a witness herein, having been first duly  
12 sworn, was examined and testified as follows:

13 EXAMINATION

14 BY MR. CRIST:

15 Q. You've been sitting there very  
16 patiently for about 15 minutes, Mr. Verner. Let  
17 me give you a chance now to speak.

18 Would you please state your name for  
19 the record?

20 A. Kevin Verner, V-e-r-n-e-r.

21 Q. And, Mr. Verner, where are you  
22 presently employed?

23 A. At WMS Industries here in Chicago.

24 Q. And what is your position there?

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1           A.       Executive vice president and general  
2 manager.

3           Q.       Where were you employed before becoming  
4 executive vice president and general manager of  
5 WMS Industries?

6           A.       R.J. Reynolds Tobacco Company.

7           Q.       And how long were you employed by  
8 Reynolds?

9           A.       Approximately 15 years.

10          Q.       Mr. Verner, I would like to spend a  
11 fair amount of time talking to you about your work  
12 at R.J. Reynolds Tobacco Company, but first let me  
13 get a little bit of background from you, if I  
14 can. Are you married?

15          A.       Yes, I am. 15 years.

16          Q.       Do you have any children?

17          A.       Yes, we do. Two girls, 8 and 6.

18          Q.       Would you please tell the jury what  
19 your educational background is, please?

20          A.       I have an undergraduate degree from the  
21 University of Michigan in economics.

22          Q.       Do you have any postgraduate training?

23          A.       Yes. I attended graduate school at the  
24 University of Toledo, 1980-1981.

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1 Q. Did you receive a degree as a result of  
2 that?

3 A. No, I did not. I did extensive course  
4 work in a field known as econometrics.

5 Q. Mr. Verner, I am handing you what has  
6 been premarked as Verner Exhibit 1. Would you  
7 please tell the jury what that is?

8 A. Yes, this is my resume.

9 Q. Mr. Verner, probably because of our  
10 hand in it, I think there was a mistake on that.  
11 Is there a correction to be made?

12 A. Yes. I am executive vice president and  
13 general manager at WMS. This listed it as vice  
14 president and general manager. The job is the  
15 same but the title is just different.

16 Q. I apologize for our mistake.

17 A. That's all right.

18 Q. Mr. Verner, make reference to that as  
19 appropriate, but could you tell the jury when it  
20 was that you first went to work for R.J. Reynolds  
21 Tobacco Company?

22 A. Yes. December of 1981.

23 Q. And what was your first job there?

24 A. I was the senior marketing research

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1 analyst in the marketing research department.

2 Q. And what kind of work were you doing?

3 A. Primarily sales forecasting,  
4 quantitative analysis, that sort of thing.

5 Q. How long did you hold that position?

6 A. Approximately two to three years.

7 Q. And although we'll come back to it in a  
8 minute -- because we'll come back to it in a  
9 minute, could you please give the jury a brief  
10 overview of your subsequent positions at Reynolds?

11 A. Yes. I went from that position into  
12 another area of marketing research within the  
13 company for a couple of years and then moved in a  
14 field that's known as brand management or brand  
15 marketing.

16 I spent several years doing various  
17 jobs in brand marketing. I became the director of  
18 public policy development and then again the vice  
19 president of new business development.

20 During that time, there was a short  
21 hiatus of about six months that I went to work at  
22 an advertising agency in Ann Arbor, Michigan  
23 called Group 243.

24 Q. And then after that, you returned to

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1 Reynolds?

2 A. Yes, sir.

3 Q. Now, I would like to ask you in more  
4 detail about each of those jobs, but first when  
5 you arrived at Reynolds, did you receive any  
6 training in the area of marketing?

7 A. Yes, extensively.

8 Q. Could you just tell us about the nature  
9 of the training you received?

10 A. Absolutely. The company has a training  
11 module where new employees into the marketing  
12 department are given very extensive background in  
13 various aspects of marketing, how we conduct our  
14 business, the legal policy and procedures, the ad  
15 code, how we -- our relationship with our ad  
16 agency, a whole variety of things that covers how  
17 we conduct our business.

18 Q. With respect to the portions of that  
19 training program that you describe relating to  
20 company policies and legal requirements, could you  
21 please elaborate on those?

22 A. Yes. Well, when an employee comes into  
23 marketing, you are provided a copy of the industry  
24 ad code and you are given the opportunity to spend

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1 at least a week or so with our lawyers going over  
2 the terms of the code, the spirit as well as the  
3 letter of the laws that exist that regulate our  
4 industry.

5 And in that training, you are  
6 introduced to the people that you interact with on  
7 a regular basis in the development of our  
8 marketing materials.

9 Q. Were the company goals with respect to  
10 advertising and marketing also a part of that  
11 training program?

12 A. Yes.

13 Q. Would you please tell the jury what it  
14 is that was taught to you at the time you joined  
15 Reynolds with respect to what the marketing and  
16 advertising goals of Reynolds were.

17 A. Absolutely. It's to increase and grow  
18 and maximize their share of adult smokers.

19 Q. And specifically, how do you go about  
20 doing that?

21 A. Through a whole variety of marketing  
22 plans and programs, the development of either  
23 brands or promotional programs or advertising  
24 programs that seek to either switch smokers,

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1           A.     No.

2           Q.     Why not?

3           A.     Well, first of all, it's against our  
4 policy and procedures to go ahead and develop  
5 materials for nonsmokers but it would be also be a  
6 waste of time and energy. I think they're not  
7 currently in the category.

8                     About 25 percent of the population does  
9 smoke, and from an advertising resource  
10 standpoint, your money is best targeted against  
11 those people that are currently in the category.

12          Q.     During your employment, Mr. Verner,  
13 were you ever asked to design a program to  
14 advertise or market cigarettes to children?

15          A.     No.

16          Q.     To your knowledge, was anybody else in  
17 the marketing department at Reynolds asked to do  
18 so?

19          A.     No.

20          Q.     If you had been asked, would you have  
21 done so?

22          A.     No.

23          Q.     Why not?

24          A.     Well, first of all, it is against the

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1 company's policies and procedures to go ahead and  
2 do that. Secondly, perhaps even more  
3 importantly, I'm a parent. I work with other  
4 people that are parents, and we target our  
5 advertising and promotional programs to adult  
6 smokers of our brands and other brands.

7 Q. Were those views that you just  
8 expressed also shared by your colleagues?

9 A. Absolutely.

10 Q. How do you know that?

11 A. We talked. We all work together. Many  
12 of us have been with the company for 10, 15 years  
13 or more.

14 Q. Wouldn't youth targeting benefit  
15 Reynolds?

16 A. No, I don't believe so.

17 Q. Why do you say that?

18 A. Well, other than the obvious reasons  
19 that to do that would bring down all sorts of  
20 criticism to this industry which would result in  
21 much stricter restrictions than exist today which  
22 would undermine our abilities to capture market  
23 share among adult smokers, which is what our  
24 target is, certainly.

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1           Also, I personally don't believe that  
2 it would really be a beneficial effort from the  
3 standpoint of they are not in the category, same  
4 reason that I gave you before. These are not  
5 users of our products.

6           Q.     Let's go back, if we can, Mr. Verner,  
7 to Exhibit 1. And you identify on there specific  
8 positions that you held after your initial tour of  
9 duty as a senior research analyst.

10           Could you please tell the jury what  
11 positions you held and at what times?

12           A.     Sure. '83 to '84, the assistant  
13 marketing research manager in marketing  
14 development. That was a position that was  
15 designed to conduct marketing research for brand  
16 management.

17           '84 to '86, the assistant brand  
18 manager on the Winston cigarette brand. '86 to  
19 '87, brand manager for new product development,  
20 new brand manager.

21           '87 to '90, the senior brand manager  
22 on the Salem cigarette brand. Then in August of  
23 '90 through February of '93, I was the director  
24 of public policy programs and development for the

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1 external relations department.

2 I returned to marketing in the new  
3 business development capacity as director,  
4 February, of '93 through December of '94 and then  
5 became vice president of new business development  
6 in December of '94 until I left the company in  
7 February of this year.

8 Q. During your employment, Mr. Verner, did  
9 your duties include market research?

10 A. Absolutely.

11 Q. Could you tell the jury what market  
12 research involved?

13 A. Sure. A couple types of marketing  
14 research, what is referred to as quantitative and  
15 qualitative research, all of them designed to help  
16 us understand what are the unmet wants product or  
17 positioning-wise for our brands.

18 Qualitative research generally referred  
19 to things like interviews and focus groups which  
20 people are brought into a room. They're shown  
21 stimulus materials. You ask them questions about  
22 those materials and try to understand the reasons  
23 for either liking or not liking a particular  
24 brand.

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1                    Quantitative research, on the other  
2 side, is really more of a larger sample of smokers  
3 that when one would bring in and show them  
4 materials and quantitatively or statistically  
5 tabulate the results.

6            Q.     Okay. Tell us how one of these focus  
7 groups might work, or how did it work perhaps?

8            A.     An outside research agency would  
9 usually via the phone dial into a household, ask  
10 to speak to any adult over the age of 21, assess  
11 whether or not they were a smoker or not, and if  
12 they were, would ask a series of questions and  
13 determine whether or not they would be interested  
14 in attending a discussion group which lasts  
15 normally about two hours, and if so, could they  
16 come to the Marriott or a research facility for  
17 two hours. And at that facility they would then  
18 be shown information and a moderator would lead  
19 them through a discussion.

20           Q.     Now, with respect to cigarette  
21 advertising and marketing practices, on whom did  
22 Reynolds conduct market research?

23           A.     Adults smokers.

24           Q.     Would you just briefly explain the

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1 difference between quantitative research and  
2 qualitative research perhaps with respect to  
3 timing and perhaps with respect to how they differ  
4 one from the other?

5 A. Sure. In general, when one is  
6 developing a marketing program or a brand, you  
7 start off with qualitative research by bringing in  
8 groups of people and try to develop an in-depth  
9 understanding as to what they like, what they  
10 don't like and how you can better service their  
11 needs or their wants.

12 You then go away and develop concepts,  
13 typically, and then when you're ready to take it  
14 to the next phase and help you understand whether  
15 or not your concept is accurately reflected what  
16 you were told, you conduct quantitative research  
17 which in many respects gets at the same  
18 information except with a much larger group of  
19 people. Instead of a dozen or two, perhaps  
20 it is a couple hundred or even thousands in some  
21 cases.

22 Q. Why -- what is it you're trying to  
23 accomplish with this market research, Mr. Verner?

24 A. Trying to find the best way to fulfill

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1 unmet wants that exist in the marketplace today.  
2 Both qualitative and quantitative research are  
3 variable tools in helping you do that.

4 Q. Does Reynolds conduct market research,  
5 for example, with respect to specific ads or ad  
6 campaigns?

7 A. Absolutely.

8 Q. Why do you do that?

9 A. Again, because advertising has an awful  
10 lot that it's attempting to accomplish. And in an  
11 attempt to maximize its relevancy to these groups,  
12 it's very important if you're going to be spending  
13 money and resources buying it to ensure that the  
14 advertising can carry that burden.

15 Q. Is it difficult for advertising to  
16 carry that burden?

17 A. It's very difficult for advertising.

18 Q. Why is that?

19 A. Well, advertising has to accomplish a  
20 lot of things. First and foremost it has to be  
21 seen or people have to be aware of it.

22 We're all surrounded by hundreds and  
23 thousands of impressions every day from all sorts  
24 of different products, and the ability to break

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1 through that clutter is enormously important.

2 If you develop an ad and nobody sees  
3 it, then it's a useless ad. Once they see it,  
4 that's not enough. It has to be something that is  
5 relevant to them. They have to look at it. They  
6 have to -- it has to be speaking directly to  
7 them.

8 They have to like it, is yet another  
9 thing. You can go ahead and develop an ad that  
10 people say maybe they like and if it's relevant,  
11 that's fine, but it has yet another hurdle and  
12 that is it has to generate purchase interest.

13 So if you are able to accomplish all  
14 those things and when you're all done somebody  
15 says I think this is something I would like to  
16 try, then you're on your way maybe to developing a  
17 good ad.

18 Q. Are their examples of ads that have not  
19 been able to accomplish that?

20 A. Oh, yes, many of them.

21 Q. Can you give me some examples?

22 A. Well, years ago there was the Joe Isuzu  
23 type of ad. I think everybody knew who Joe Isuzu  
24 was. Nobody, unfortunately for them, I

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1 guess, bought the product.

2 Alka-Seltzer many years ago ran, I  
3 think it was, I can't believe I ate the whole  
4 thing. And that was very a memorable ad campaign,  
5 but did it result in any higher sales?

6 The ad business and marketing is  
7 literally cluttered with lots of brands and ad  
8 campaigns that fail to meet one or more of those  
9 criteria.

10 Q. Mr. Verner, are you familiar with the  
11 term advertising clutter?

12 A. Yeah.

13 Q. What does the term advertising clutter  
14 mean?

15 A. Well, again, there is thousands of  
16 images that we are exposed to every day, whether  
17 it's on television or radio or in newspapers or  
18 magazines. And the clutter is simply the noise  
19 that exists, and an attempt to break through that  
20 clutter and being noticeable, it's very difficult  
21 to do.

22 Q. What kinds of things can somebody in  
23 advertising or marketing attempt to do to cut  
24 through that clutter?

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1           A.     Use a graphic design, maybe color,  
2     bright colors, depending on the environment that  
3     you're trying to promote your product in. Could  
4     be use of lights. Neon is an example of what  
5     somebody might do.

6                     Spokespeople, celebrities. You've seen  
7     lots of products that are advertised with  
8     well-known celebrities. These are all things that  
9     marketers try to do. Maybe even the form of the  
10    ad. For example, some advertisers run two-page or  
11    what are known as gate-fold ads, open up, several  
12    pages.

13                    These are all designed to really meet  
14    that first issue I raised earlier which is  
15    awareness to try to generate awareness.

16           Q.     I wanted to come back just for a  
17    second, Mr. Verner, and -- previously you  
18    indicated that in 1990 you left the marketing  
19    department?

20           A.     Yes, sir.

21           Q.     And what did you do at that point in  
22    time?

23           A.     Went to a department called public  
24    policy development.

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1 Q. And what did public policy development  
2 involve?

3 A. That was really the department in -- my  
4 position within that department was to develop and  
5 identify the youth nonsmoking programs that the  
6 company later developed.

7 Q. How did you personally get started or  
8 involved in this area in 1990?

9 A. We started off really by taking a look  
10 at what existed within the industry, what types of  
11 programs were we running, what type of programs  
12 did the Tobacco Institute or the tobacco industry,  
13 what were they running, what was running in the  
14 school systems, what was in the press, what was in  
15 the literature that was available and the types of  
16 programs that were out there.

17 We looked at government surveys and the  
18 rest, and then ultimately decided on a position  
19 that went to the chairman of our company at that  
20 time and instructed him that there were things  
21 that could be done.

22 There were niches and holes that could  
23 be filled and that these were the types of program  
24 ideas that we were looking at and addressing.

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1 Q. And what was the purpose of this  
2 program?

3 A. To go ahead and discourage youth  
4 smoking.

5 Q. Okay. Now, let me show you what has  
6 been marked -- premarked as Verner Exhibit 2 and  
7 we have that -- lost my microphone. We have that  
8 in a reduced version. We also have it on a  
9 posterboard size.

10 A. Does it matter to you which one I use?

11 Q. No, either one. I think that the  
12 posterboard size is too small for the camera to be  
13 able to pick up here. So use whichever one is  
14 more convenient to you.

15 A. Okay.

16 Q. Would you please tell the jury what  
17 that represents, Mr. Verner?

18 A. Yes. It's a chronological chart  
19 starting in 1960 that really outlines the history  
20 of RJR's and the Tobacco Institute's youth  
21 nonsmoking programs and efforts.

22 Q. Does it include additional information  
23 as well?

24 A. Yes, it does. There are three rows

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1 here that segregate the information by what was  
2 going on in terms of public health and government  
3 activities since 1960, some of the prevailing  
4 educational and social theories in terms of what  
5 it took to discourage underage smoking.

6 And it concludes with a chart showing  
7 what RJR and industry responses were to some of  
8 the issues that were raised during that time.

9 Q. Would this chart, Mr. Verner, be  
10 helpful to you in describing to the jury the  
11 various youth nonsmoking activities in which  
12 Reynolds has been involved over the decades?

13 A. Yes, it would.

14 Q. Could you please describe to the jury  
15 how it is that the information on that chart is  
16 laid out?

17 A. Yeah. There are three rows that,  
18 again, from 1960 up until the current, that  
19 outlines a variety of materials that were in place  
20 from a public health and from a governmental  
21 activities standpoint.

22 And then goes on to talk about how  
23 those were reflected perhaps in the educational  
24 social theories at the time that were being put in

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1 place in the school systems, and then again what  
2 our programs and what the industry programs were  
3 about during those same years.

4 Q. And this begins at approximately what  
5 time?

6 A. 1960.

7 Q. And the chart simply does not go  
8 further back in time than that, is that right?

9 A. No, sir, it does not.

10 Q. Let's go through those columns of rows,  
11 if we can. First could you tell the jury what it  
12 is that appears across the first row?

13 A. Yes. It's entitled "Public Health and  
14 Governmental Activities," and it outlines various  
15 activities going back to the Surgeon General's  
16 report in 1964 up to more current periods of time.

17 And it also documents type of  
18 information that was available, typically  
19 government studies, things that were surveys,  
20 polling data, that was available back then as well  
21 as more recently.

22 Q. Government studies, surveys and polling  
23 data with respect to?

24 A. Underage smoking, the incidence of

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1 youth smoking and some other limited information  
2 in terms of the reasons and motives behind it.

3 Q. And this was data which was collected  
4 by the government?

5 A. Yes, sir.

6 Q. And it was among the information which  
7 you assembled to help you put together --

8 A. Yes, it was.

9 Q. Now, look at the next column, if you  
10 would, with me, the middle column. It's entitled  
11 "Educational and Social Theories." What does  
12 that refer to?

13 A. When you look back over time as to what  
14 was the wisdom at the time in terms of the types  
15 of information that can imparted to underage  
16 people to discourage them from smoking, this  
17 documents really an evolution that shows up until  
18 essentially 1980 the use of informing children  
19 that smoking was harmful to their health was seen  
20 as a deterrent to initiation. That was the  
21 prevailing theory that existed at the time.

22 Around 1980 that started to change and  
23 it got into more sophisticated types of programs  
24 that talked about self-esteem, decision-making

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1 process, cognitive skills and behavior models  
2 which were in response, in essence, to a floor  
3 being reached on the youth nonsmoking rates and an  
4 attempt to go look for other ways to further  
5 reduce underage smoking.

6 And it -- the row concludes with more  
7 recently in 1990 a lot of information and programs  
8 on the importance of reducing the access of the  
9 product at retail.

10 Q. Mr. Verner, with respect to the  
11 deterrence approach which had been used, does that  
12 continue to be used?

13 A. Yes, yes, absolutely. In fact, it's  
14 the prevailing thing still, I think, even to this  
15 day in schools.

16 Q. To what extent, Mr. Verner, based upon  
17 the work that you did in putting together  
18 Reynolds's youth nonsmoking program did you find  
19 that the deterrence approach worked?

20 A. Well, it certainly worked back in the  
21 early days, and there has been a fairly large  
22 decline overall historically in underage smoking.

23 Around the mid 1970s, though, as I  
24 mentioned earlier, there was a floor that was

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1 reached. And at that time public health officials  
2 and the school systems and states started to look  
3 at other ways in which they may be able to make  
4 further declines in underage smoking, and that's  
5 where the evolution of these more complex types of  
6 programs came from.

7 Q. Okay. Now, let's look at the bottom  
8 row for a second, Mr. Verner. It's entitled "RJR  
9 Industry Responses," correct?

10 A. Yes.

11 Q. And would you tell the jury what it is  
12 that that row reflects?

13 A. Yes. It's example of the types of  
14 programs, materials and voluntary efforts on this  
15 industry's part, or in case here, of R.J.  
16 Reynolds' part of programs that we put in place  
17 chronologically that were designed to address the  
18 underage smoking issue.

19 Q. Okay. And again, since that begins in  
20 1960, let's begin there. What kinds of things was  
21 Reynolds doing beginning in the 1960s to  
22 discourage youth from smoking?

23 A. An example here in 1964 was the  
24 adoption by the industry of what's known as the

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1 Cigarette Advertising Code.

2 Q. Let me just stop you if I can. Are you  
3 familiar with the content of that code?

4 A. Yes, sir, I am.

5 Q. Let me show you, Mr. Verner, what's  
6 been premarked as Exhibit 3. And we have that,  
7 again, both reduced form and expanded form. I  
8 don't know if the camera is going to be able to  
9 pick that up, but perhaps you could -- first of  
10 all, do you recognize that what is?

11 A. Yes, absolutely. It's a summary,  
12 really, of some of the key provisions in the ad  
13 code of '64.

14 Q. And would using that exhibit help you  
15 to explain to the jury what the substance of the  
16 advertising provisions of the ad code were?

17 A. Certainly.

18 Q. Go ahead and proceed.

19 A. Okay. It starts off here talking about  
20 some provision related to ad placement, and back  
21 in 1964 it designated if you were advertising on  
22 television or radio, you needed to make sure that  
23 it was done in programming that was directed  
24 primarily to persons that were at least 21 or

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1 older.

2 Certainly no advertising in school,  
3 college, university, media or comic books. Also  
4 talked about a variety of content restrictions.  
5 For example, if you were using a model, the model  
6 had to be over 25 years of age. Cigarette smoke  
7 couldn't be shown in exaggerated manner. You  
8 couldn't use a well-known athlete or celebrity  
9 spokesperson in advertising your product.

10 Also in addition, additional  
11 restrictions looked at things along the lines of  
12 the inability at this time to go ahead and  
13 advertise the tar content of cigarettes.

14 And it specified from a product  
15 standpoint that samples or free cigarettes, if you  
16 will, cannot be distributed to people under the  
17 age of 21 and nor could you do this practice on  
18 school, university or college campuses.

19 Q. And that was adopted in 19 --

20 A. 1964.

21 Q. Okay. Now, Mr. Verner, let's go back,  
22 if we can, to Exhibit 2 which is the chart with  
23 the three rows on it.

24 What is the next entry that appears on

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1 there with respect to the Reynolds' efforts to  
2 discourage youth smoking?

3 A. In 1969, the industry volunteered to  
4 withdraw from broadcast television and radio,  
5 assuming that we could get out of contracts that  
6 existed with the networks at that time for the ad  
7 space. And that was in 1969.

8 Q. Do you know why?

9 A. Yeah. At the time the industry -- and  
10 there was a great deal of interest and attention  
11 being targeted toward did broadcast, whether it  
12 was television or radio, have some sort of  
13 differential appeal to underage people and was it  
14 another -- was it perhaps too intrusive for this  
15 category.

16 So in '69, the industry volunteered to  
17 remove itself from the air waves assuming, again,  
18 they could get out of commitments that had made  
19 with the networks.

20 Q. Did that happen?

21 A. Yes, it happened and it was enacted by  
22 law in 1971.

23 Q. And it took effect in 1971. Do you  
24 know when?

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1 A. It was January 2nd, I believe, or 3rd.

2 Q. Very early that year?

3 A. Very early.

4 Q. Okay. Now, there is also a reference  
5 on there, is there not, to a sampling code?

6 A. Yes, sir, 1981 to '83.

7 Q. Are you familiar with the sampling  
8 code?

9 A. Yes, I am.

10 Q. Was that also something which was a  
11 part of your training when you joined Reynolds?

12 A. Absolutely.

13 Q. I would like to hand you, Mr. Verner,  
14 what has been marked as Verner Deposition Exhibit  
15 No. 4 which we have in both reduced form as well  
16 as in a blow-up form.

17 A. Okay.

18 Q. Would you please identify that for the  
19 jury?

20 A. Yes. Again, it's a summary of some of  
21 the key provisions of the Sampling Code of  
22 Practice from 1983. This is essentially the same  
23 as what it was in 1981. So for practical  
24 purposes, it goes back to '81.

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1           It talks about the restrictions in  
2 distribution of samples, stating that no samples  
3 are --

4                   (WHEREUPON, discussion was had  
5 off the record.)

6 BY THE WITNESS:

7           A.       I'm sorry. -- stating that no samples  
8 can be given to persons under the age of 21;  
9 certainly no sampling in public places that are in  
10 close proximity to areas where youths congregate,  
11 such as playgrounds or schools or college  
12 campuses; cannot send cigarettes samples  
13 unsolicited through the mails, and no samples can  
14 be distributed to people while they're in a car.

15                   It also talks a bit about the  
16 restrictions on persons conducting the sampling in  
17 terms of not urging anyone, even if they're an  
18 adult over the age of 21, to accept a sample.

19                   They are intended only for smokers, and  
20 they specify that to people, and other things like  
21 disposing of litter, since they are sampling  
22 sometimes in public places.

23                   And the termination of sampling which  
24 simply specifies that they if happen to be in an

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1 area where all of a sudden the profile of the  
2 complexion of the people in the area changes and  
3 maybe there is a bunch of children that come  
4 around, that they are to terminate their sampling  
5 practices.

6 Q. Mr. Verner, the original advertising  
7 code, as I understood it, had provisions that  
8 related to cigarette sampling?

9 A. Yes, it did.

10 Q. And this was an expanded code that was  
11 adopted in 1983?

12 A. Yes, sir.

13 Q. I think I may have mislead you a second  
14 ago. With respect to the marketing training that  
15 you took when you first arrived at Reynolds, that  
16 was 1981. So evidently it predated this?

17 A. Yes.

18 Q. So I guess my earlier question should  
19 have been the cigarette sampling practices among  
20 the subjects of your training.

21 A. Oh, yes, absolutely.

22 Q. I apologize for the confusion my  
23 question may have generated.

24 A. That's okay.

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1       Q.     Now, Mr. Verner, I would like to show  
2     you what has been premarked as Verner Exhibit No.  
3     5 which we also -- which we have both in reduced  
4     version and in expanded version. And would you  
5     please tell the jury what this is?

6       A.     Yes. This is the, again, summary  
7     points from the Cigarette Advertising and  
8     Promotion Code of 1990 which brings together the  
9     ad code and the promotion code and was updated in  
10    1990.

11            It expands on primarily the promotion  
12    and the sampling areas of the code. Again, same  
13    sort of points that we mentioned earlier in terms  
14    of the restrictions on advertising placements,  
15    talking about making sure that the publications  
16    were directed primarily to the people under the  
17    age of 21, specifying that advertising shall not  
18    appear on billboards within 500 feet of any school  
19    and restrictions on the advertising contents.

20            Again, things similar to what we  
21    discussed before, that nobody depicted in the ads  
22    can be under the age of 25. Same thing in terms  
23    of celebrity spokespeople.

24            It has a more expanded area as it

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1 relates to product sampling. It respecified again  
2 some of the key provisions of the '81 and '83  
3 sampling code. But it goes on further to talk  
4 about the compliance that is being demanded  
5 contractually by the suppliers who tend to do the  
6 product sampling for the companies and what the  
7 terms are that they must agree to in provisions  
8 for auditing of them.

9 And it talks about restrictions on other  
10 promotional activities which are primarily the  
11 distribution of what's referred to here as  
12 nontobacco premium items bearing a cigarette brand  
13 name or logo without having written consent from  
14 the individual saying they're 21 years of age or  
15 older and they are indeed a smoker.

16 Q. Now, Mr. Verner, going back to the  
17 chart which I believe was marked as Exhibit 2,  
18 there is a reference on here to the fact that in  
19 about 1980, the cognitive and social and  
20 behavioral models began to change?

21 A. That's right.

22 Q. At about that time, did the efforts of  
23 Reynolds and others, perhaps, in the industry  
24 begin to change as well?

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1           A.       Yes, sir.

2           Q.       What specifically did Reynolds or, for  
3 that matter to the extent you know, others do with  
4 respect to these new theories of deterrence of  
5 youth do?

6           A.       Well, again, at around 1983, Reynolds  
7 started running a series of ads in publications,  
8 including some that were directed specifically at  
9 children, urging them not to smoke.

10                   And simultaneously the Tobacco  
11 Institute started running what is known as a  
12 responsible living campaign which were materials  
13 that were targeted to parents to help them talk to  
14 children.

15           Q.       Mr. Verner, let me show you what have  
16 been premarked as Verner Deposition Exhibits 6  
17 through 9, and ask you if you would identify  
18 those, please?

19           A.       Thank you. Yes. These are the samples  
20 of really what are editorial ads, if you will,  
21 that R.J. Reynolds ran in a number of  
22 publications, including those that are targeted to  
23 youth.

24           Q.       Can you just identify for the jury and

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1 perhaps show to the camera what each of those is?

2 A. Sure.

3 Q. First is No. 6?

4 A. Yes, sir. I'll just read the  
5 headline. "Some Straight Talk About Smoking For  
6 Young People." "Does Smoking Really Make You Look  
7 More Grown Up?" "How To Handle Peer Pressure."  
8 "Some Surprising Advice to Young People From R.J.  
9 Reynolds Tobacco."

10 Q. Now, you indicated, Mr. Verner, that  
11 those statements ran in various media, including  
12 media which were directed towards youth?

13 A. That's correct.

14 Q. Would you please give the jury an idea  
15 some of the publications directed towards youth in  
16 which those statements, Verner Exhibits 7 through  
17 9, ran?

18 A. Yeah. Magazines entitled things like  
19 Tiger Beat, Miss, Boys Life, I believe, Atari Game  
20 or Atari World, which was a game-type of magazine,  
21 magazines which were very clearly targeted to  
22 people under the -- early adolescence or younger.

23 Q. Mr. Verner, has -- did any of those  
24 four statements that you just referred to -- and I

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1 may have the exhibit numbers wrong. I think it  
2 was --

3 A. It's 6, 7, 8 and 9.

4 Q. 6 through 9, did any of those have any  
5 brand identification on them whatsoever?

6 A. No, sir.

7 Q. Mr. Verner, has -- with respect to the  
8 youth-directed media in which those statements  
9 appeared, has Reynolds, to your knowledge, ever  
10 run cigarette advertising in those youth-oriented  
11 media?

12 A. Absolutely not.

13 Q. And why?

14 A. Well, because, again, they are  
15 targeted -- their primary target and their  
16 primarily readership is well under the age of 21.  
17 It's specified, again, in our code that we  
18 wouldn't do that nor would the company run those  
19 types of magazines.

20 Q. Why, Mr. Verner, did Reynolds run these  
21 youth nonsmoking statements?

22 A. Well, first of all, to deliver the  
23 message not to smoke to young people, and we felt  
24 that it would be particularly compelling to let

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1 them know that this was a tobacco company that was  
2 delivering that message to them.

3 Q. You referred to a program that was  
4 sponsored by the Tobacco Institute.

5 A. Yes.

6 Q. What was that called?

7 A. The responsible living campaign.

8 Q. And what was its purpose?

9 A. That was parent-directed. It was two  
10 brochures or two booklets, actually, that were  
11 designed to help parents talk to their children  
12 about making decisions, talk to them about not  
13 smoking and other lifestyle behaviors, really to  
14 assist parents do their job in having a dialogue  
15 with the children.

16 Q. Other than the Tobacco Institute, was  
17 anybody else involved in this responsible living  
18 program?

19 A. Yes, absolutely.

20 Q. Who?

21 A. It was an association that the name  
22 escapes me now but I believe it was the National  
23 Association of School Board Educators or something  
24 along those lines.

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1 Q. Okay.

2 A. I believe it's on the material.

3 Q. Well, let me just show you then, if I  
4 can, Mr. Verner, what have been marked as Verner  
5 Deposition Exhibits 10 and 11, and first ask you  
6 if you can identify these?

7 A. Yes. This is called "Helping youth  
8 decide," Exhibit 10. This is what I was referring  
9 to earlier developed with the National Association  
10 Of State Boards Of Education.

11 Q. That was the National Association Of  
12 State Boards Of Education?

13 A. Yes. National Association of State  
14 Boards of Education, NASBE, I guess. And  
15 "Tobacco: Helping Youth To Say No, A parents'  
16 Guide To Helping Teenagers Cope With Peer  
17 Pressure." That's Exhibit 11.

18 Q. Okay. With respect to Exhibit 10,  
19 Helping Youth Decide, would you please just  
20 briefly describe that brochure and its purpose?

21 A. Sure. This as well as this other piece  
22 of material here were designed to help parents  
23 engage in a dialogue with their children, whether  
24 it's on smoking or any other lifestyle behavior

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1 that kids in these age groups tend to be exposed  
2 to, to talk to them about how to handle conflict  
3 with their children, how to handle conversations  
4 that might be difficult in starting up and  
5 having.

6 I would say its primary thrust is to  
7 encourage parents to play an active role if  
8 they're not already in dealing with not only  
9 smoking but other lifestyle behavior issues that  
10 are important to children in that age group.

11 Q. With respect as to Exhibit 11, what was  
12 its focus?

13 A. Specifically on helping parents talk to  
14 their children about having their children make a  
15 no-smoking decision.

16 Q. Now, both 10 -- Exhibits 10 and 11 are  
17 in the English language. Were there other  
18 languages which were also used?

19 A. Yes. Spanish.

20 Q. Now, in 1990, if I recall your  
21 testimony correctly, you became the director of  
22 public policy development, correct?

23 A. Yes.

24 Q. But that was not in the marketing

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1 department?

2 A. No, no. It was in external relations.

3 Q. Now, how did you -- strike that. And  
4 that was in 1990, correct?

5 A. Yes, sir.

6 Q. Now, in 1990, how did you go about  
7 getting started on this youth nonsmoking effort in  
8 which you were involved?

9 A. Well, you start by taking a historical  
10 look at what has been done by the industry and by  
11 others.

12 You also start by soliciting advice and  
13 consultation from experts in the field and ask  
14 them how they would approach and tackle the  
15 problem. And once one has done that, you do start  
16 to develop theories and concepts on the key  
17 components of the programs and start to research  
18 them.

19 Q. Can you give us an example of  
20 historical materials you looked at?

21 A. Absolutely. We looked at what was  
22 going on in the school systems at that time.  
23 There was also a very helpful document that was  
24 done by the Department of Health and Human

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1 Services that did we what thought was an excellent  
2 job of summarizing the history of youth nonsmoking  
3 programs and materials, and we used that very  
4 extensively.

5 Q. Mr. Verner, let me show you what has  
6 been marked Deposition Exhibit 27. Is that a copy  
7 of that Health and Human Services book you  
8 described?

9 A. Yes. It's entitled "Strategies to  
10 Control Tobacco Use in the United States, A  
11 Blueprint For Public Health Action in the '90s,"  
12 done by the Department of Health and Human  
13 Services.

14 Q. Now, Mr. Verner, I would like to hand  
15 you what have been marked as Verner deposition  
16 Exhibits No. 12 and No. 13.

17 Mr. Verner, what are these?

18 A. These are two documents that summarize  
19 the background, development of the youth  
20 nonsmoking effort, talks about the strategies that  
21 the external relations department employed in  
22 developing those programs.

23 And then Exhibit 13 is a much more  
24 detailed outline that talks about the history of

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1 the development of the programs and specifically  
2 outlines a lot of the quantitative research that  
3 was conducted on the materials.

4 Q. Mr. Verner, who wrote Exhibits 12 and  
5 13?

6 A. I did.

7 Q. And when did you do that?

8 A. Neighborhood of '90, '91, '92, early  
9 '90s.

10 Q. Okay. With respect to the development  
11 of this program, Mr. Verner, you had indicated  
12 that not only did you look at historical matters  
13 but that you also consulted with various experts.

14 A. Yes, sir.

15 Q. Would you please identify those  
16 individuals and what their role was?

17 A. Sure. Well, there were four of them  
18 primarily, Dr. Joseph Adelson who is a child  
19 psychiatrist at the University of Michigan; Dr.  
20 Martha Sharpless who is an M.D. in Greensboro,  
21 North Carolina, a pediatrician; Hernan LaFontaine,  
22 a former educator; and woman by the name of  
23 Floretta McKenzie, who is the former  
24 superintendent of schools in the District of

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1 Columbia.

2 And their role was primarily for us at  
3 the beginning to sit down and talk with them about  
4 what it is we were trying to accomplish, their  
5 thoughts on the best way to accomplish it and what  
6 they thought the relevant messages would be.

7 And then as we developed creative  
8 materials, programs, we used them to review those  
9 program materials before we sent them out and  
10 researched them.

11 Q. Okay. With respect to this youth  
12 nonsmoking program, Mr. Verner, I would like to  
13 invite your attention back to Exhibit 13, if I  
14 could, and specifically the first page of it.

15 A. Uh-huh.

16 Q. And under item Roman numeral 1-D, there  
17 are three programmatic elements, is that correct?

18 A. Yes, sir.

19 Q. Would you please tell the jury what  
20 those three programmatic elements were.

21 A. Right. We were taking a look at what  
22 kind of niche we would fill to supplement or  
23 compliment existing programs that existed trying  
24 to discourage children from smoking.

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1           And we decided to take a three-pronged  
2 approach; the first being materials and programs  
3 that were directed specifically at youth, and then  
4 programs and materials to help parents do their  
5 job in talking with their children about not  
6 smoking, and then finally the component for  
7 retailers to help them understand the importance  
8 of complying with minimum age laws and how to  
9 enforce it themselves.

10           Q.     So as I understand it, the three  
11 elements were youth-directed, parent-directed?

12           A.     Parents.

13           Q.     And retailer-directed?

14           A.     Yes, sir.

15           Q.     I'm going to ask you about each of  
16 those elements in a minute, but was there a name  
17 for this effort?

18           A.     Yes. We called it Right Decisions  
19 Right Now.

20           Q.     And how did you come to choose that  
21 name?

22           A.     It's catchy and it speaks to decisions  
23 which is really the overall theme here, how to  
24 make a right decision, and that decision being not

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1 to smoke if you're a child. It also looked good  
2 as a logo.

3 Q. Now, let's turn to each of those three  
4 elements and let's start with student-directed  
5 materials.

6 First just in general describe the  
7 kinds of materials or the categories of materials  
8 which you developed.

9 A. Yes. There were quite a few ranging  
10 from ads that could take the form of posters that  
11 were in schools or table tent cards or book  
12 covers, brochures that are in the school systems  
13 as well as materials that were workbooks that were  
14 distributed by the schools.

15 Q. And, secondly, by way of introduction,  
16 at what age group were these materials targeted?

17 A. These were targeted to children that  
18 were in what are referred to as middle school or  
19 junior high school levels. Most of them are  
20 between the ages of 12 and 15.

21 Q. Why did you pick that age?

22 A. Well, again, that's what the experts  
23 were leading us down that direction. Most of the  
24 literature notes that by that age, that's a time

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1 when children are making some very important  
2 decisions, smoking being one of them, and other  
3 lifestyle behaviors.

4 After that, many times the decisions  
5 have already been made. Before that, they are  
6 much too young. The age of initiation and  
7 experimentation according to the experts in some  
8 of the studies we reviewed were in this critical  
9 age area and that's where we decided to focus our  
10 energies.

11 Q. With respect as to the kinds of  
12 materials that were ultimately developed, would  
13 you just briefly describe the process by which  
14 these materials were developed?

15 A. Yes. Very similar to any other type of  
16 marketing research, concepts were developed.  
17 Those concepts were screened by our experts or our  
18 consultants and then we conducted marketing  
19 research with children and their parents.

20 Q. You conducted marketing research with  
21 children?

22 A. Yes, sir.

23 Q. At the time that you did that, had you  
24 sought permission or approval from anyone?

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1       A.     Yes, absolutely. The way it was  
2 conducted was that, once again, an outside  
3 research firm would call into the house, speak  
4 with a parent, assess whether or not they had a  
5 child that was in junior high or middle school,  
6 inform that parent that research was being done on  
7 some antismoking or nonsmoking program materials;  
8 would they allow their child to be involved in an  
9 hour to two long discussion on those materials.

10             And then the parents themselves were  
11 given an opportunity after that research to review  
12 the materials.

13       Q.     Mr. Verner, who was involved in these  
14 meetings or sessions or focus groups, perhaps,  
15 with the children?

16       A.     Who was involved? A moderator who led  
17 the group discussion.

18       Q.     Was this moderator from the external  
19 relations branch of Reynolds?

20       A.     Oh, yes. Yeah. The moderator was in  
21 many cases somebody that was hired by the company  
22 to specifically lead a discussion with kids, but  
23 it was members of the external relations  
24 department that were developing these materials

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1       were also involved.

2               Q.       Was anybody from Reynolds marketing  
3       department involved in this?

4               A.       No, sir.

5               Q.       Why not?

6               A.       Well, again, these were programs and  
7       materials designed to talk to children about not  
8       smoking, and it certainly wouldn't be appropriate  
9       at all for somebody in the brand marketing area to  
10      be involved in that. It's not relevant  
11      information for them.

12              Q.       With respect to the information which  
13      was developed as a result of the focus groups with  
14      either the children or their parents, was that  
15      information provided to the marketing department?

16              A.       No.

17              Q.       Why not?

18              A.       Again, for the same reasons. It's not  
19      applicable to the job that it is they are trying  
20      to do. This was information materials  
21      specifically related to nonsmoking efforts with  
22      children.

23              Q.       Now, with respect to the marketing  
24      research on the youth nonsmoking materials with

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1 the children and parents, what conclusions did you  
2 draw from those sessions?

3 A. Well, that there was a need to fill the  
4 niche that we were looking to fill, and the  
5 program materials and the types of messages that  
6 we had developed were doing a very good job of  
7 addressing those.

8 MR. CRIST: Why don't we take a quick break  
9 here. Off the record.

10 THE VIDEOGRAPHER: We're going off the  
11 videotape at 2:27 p.m.

12 (WHEREUPON, a recess was had.)

13 THE VIDEOGRAPHER: We're going back on the  
14 video record 2:34 p.m.

15 BY MR. CRIST:

16 Q. Mr. Verner, when we took our break, we  
17 were talking about the focus group work which you  
18 did with respect to some of the child-directed  
19 materials.

20 Did those focus groups also tell you  
21 anything with respect to the tonality or the  
22 content of those materials?

23 A. Yes, very much so. The -- the children  
24 were talking about one of the things that was

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1 appealing about the materials that we had  
2 developed is that their tonality -- they weren't  
3 preachy. It wasn't talking down to them. It  
4 wasn't depicting smoking in a bizarre or unusual  
5 way, and they like the fact that it was dealing  
6 with peer pressure and social acceptability in a  
7 nonpreachy manner.

8 Q. Did they compare that with other  
9 materials that they had seen?

10 A. Yes, and they liked them. These  
11 materials did very well. There was some  
12 quantitative data which was included in that  
13 report which talked about what their reactions to  
14 the materials were.

15 Q. Okay. Did you also take these  
16 materials to your experts?

17 A. Yes, we did.

18 Q. And did you also take them to the  
19 parents?

20 A. Yes, we did.

21 Q. After the focus group work which you  
22 had conducted, how did you actually go about  
23 developing the program materials themselves?

24 A. Sorry. I don't --

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1           Q.     That's my -- I apologize. Withdraw  
2     that question and move to another.

3                     With respect to the actual executions,  
4     who prepared those?

5           A.     We did.

6           Q.     And what was then done with them?

7           A.     We took them and we showed them to the  
8     consultants or the experts. They took a look at  
9     them, made sure that the message was an  
10    appropriate message, a nonsmoking message to the  
11    children. And we exposed them to the children,  
12    conducted our research with them, and exposed them  
13    to the parents.

14          Q.     Earlier when we were talking about  
15    cigarette advertising or perhaps marketing  
16    research in general, you identified four criteria,  
17    awareness, likability, relevance and their  
18    purchase intent. Were the same kind of criteria  
19    basically applied here as well?

20          A.     Certainly. I mean exact same process,  
21    actually. You start with the qualitative research  
22    and develop and refine your concepts and head into  
23    the quantitative research phase.

24          Q.     In connection with your exposing the

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1 children and parents to these materials, did --  
2 were they made aware of the fact that these had  
3 been developed by a tobacco company?

4 A. No. On the youth-directed materials,  
5 the children themselves did not know because  
6 Reynolds is not listed on the materials. So we  
7 conducted our research on the ads themselves  
8 without the children knowing who developed them  
9 and we showed the parents the ads.

10 And then after we had shown the parents  
11 the ads, they had a chance to talk about them, and  
12 then we discussed with them the fact that this  
13 was done by a tobacco company.

14 Q. Mr. Verner, if you would turn back to  
15 Exhibit 13, at page 5. Does that summarize some  
16 of the conclusions that you drew from these  
17 sessions with children and parents?

18 A. Yes, it does.

19 Q. And would you please explain to the  
20 jury what conclusions you were able to draw as a  
21 result of exposing these youth nonsmoking  
22 materials to children and their parents.

23 A. Sure. Again, a lot of the types of  
24 attributes we're looking to measure here are

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1           We didn't want to be in a situation  
2 where somebody saw the ads would say, oh, that was  
3 a tobacco company ad. So we were pleased that 95  
4 percent thought they were coming from a public  
5 health agency.

6           93 percent important that they thought  
7 it would be a good idea to put the ads into their  
8 school. Which, again, the experience from these  
9 kids is that they would have told you otherwise,  
10 and the fact that 93 percent thought it was a good  
11 idea was good.

12           69 percent said that the ads made them  
13 dislike smoking more than before. Not one of the  
14 children involved in the research said that it  
15 made them feel better about smoking.

16           And that is very important too because  
17 we know that these materials were going to be  
18 scrutinized greatly by the outside world and we  
19 wanted to ensure that it made kids dislike smoking  
20 because that's the message that we were trying to  
21 put out.

22           And 70 percent felt that the ads were  
23 designed for people their age, which, again is  
24 very important. We didn't want them to see these

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1 as being more appealing to people who were older  
2 or people who were younger.

3 In marketing, targeting is very  
4 important, and this was a very narrow age group  
5 and they saw this as being targeted to them.

6 Q. Mr. Verner, what about the reactions of  
7 the parents?

8 A. It was very positive really on a couple  
9 dimensions. First of all, the parents believed  
10 that peer pressure was a major issue associated  
11 with not only the decision to smoke but the  
12 decision to do lots of other things in that age  
13 group.

14 And the fact that these materials were  
15 very much targeted to peer pressure, social  
16 acceptability, decision-making was very important  
17 to them.

18 Also at the end of the research, as I  
19 mentioned, the parents had an opportunity to guess  
20 as to who developed these program materials, and  
21 they were shocked to find out that it was a  
22 tobacco company that had actually done this and  
23 had developed these materials.

24 Q. Okay. Let's take a couple of minutes,

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1 Mr. Verner, and talk about some of these  
2 materials, if we can.

3 Let me show you what have been marked  
4 as Verner Deposition Exhibits 14 through Verner  
5 Deposition Exhibit 26. And perhaps here we can  
6 hand you the posterboard size and we'll have then  
7 the small size actually inserted into the record.

8 First, Mr. Verner, what size was  
9 actually used in these executions; was it the  
10 small size or was it the --

11 A. It was the large posters here.

12 Q. Okay. And have you had a chance to go  
13 through those, Mr. Verner, and do you recognize  
14 them as being part of this youth nonsmoking effort  
15 by Reynolds?

16 A. Yes, sir.

17 Q. Would you please describe for the jury  
18 at least a sampling of the posters that were  
19 actually employed as part of this youth nonsmoking  
20 program?

21 A. Okay. I'll read the headlines, just  
22 briefly describe what's going on.

23 This is an example of some kids  
24 throwing a pack of cigarettes into a trash can and

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1 the title says "Share A Great Idea With Your  
2 Friends," basically getting rid of cigarettes,  
3 smoking.

4 "How Can Smoking Be The Thing To Do If  
5 Most Of Your Friends Aren't Doing It?" The ad  
6 depicts two kids smoking and a bunch of them not  
7 smoking. And this is very important here because  
8 it is designed to try to debunk the notion that  
9 everybody that you know smokes, which is not the  
10 case at all. So this is very graphically  
11 depicting that.

12 This was one of the original ads. "And  
13 You Think This Looks Cool?" It shows two kids  
14 sneaking a cigarette in a bathroom. And this was  
15 very well-received by the kids because they saw  
16 this as graphically showing that more or less you  
17 just look like you're sneaking something and it  
18 isn't really very attractive. You're in a  
19 bathroom. So that was the message there.

20 "Don't Create A Smoke Screen Between  
21 You And Your Friends," again, graphically  
22 depicting separation between somebody and their  
23 friends, showing that the majority of your friends  
24 do not smoke.

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1                   This one says "The Choice Is Yours,  
2                   Don't Blow It," and here it shows somebody  
3                   offering a kid the cigarette. The choice he is  
4                   making is not to smoke and not to do it. It's his  
5                   decision and that decision is to decide not to  
6                   smoke.

7                   "Smoke Signals May Not Be The Way To  
8                   Get Your Message Across." Here the young guy is  
9                   trying to impress a couple of girls who are  
10                  closing the window on him because they don't like  
11                  the fact this he's smoking cigarettes, again  
12                  designed to graphically depict the separation  
13                  between you think this is cool; it's not.

14                 Along the same lines, "And You Thought  
15                 You Knew What It Took To Fit In," again showing  
16                 kids on the bleachers where somebody is smoking.  
17                 The rest of them are over here, showing the  
18                 isolation between the two groups. And several  
19                 others along the same vein. Do you want me to  
20                 read them?

21                 Q.       Why don't you just held them up real  
22                 quickly?

23                 A.       "If You're Counting On Support For Your  
24                 Smoking, Count Again."

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1                    "If Smoking Made You More Attractive,  
2 You Would Look Better Doing It" and showing  
3 somebody with dirty ashes.

4                    "Want To Be In? Smoking Cuts You  
5 Out," showing the smoking person missing from the  
6 picture.

7                    "Your Big Ideas About Smoking Are A  
8 Lot Smaller Than You Think," showing how are you  
9 going to feel if they're not smoking, that you  
10 would look like a clown and, again, showing the  
11 isolation, "If You Think Smoking Makes You Fit In,  
12 think again."

13            Q.        Mr. Verner, one of the things that I  
14 noticed going through these exhibits as you have,  
15 that they use illustrations?

16            A.        Yes, sir.

17            Q.        Why is that?

18            A.        Well, when we're dealing with people in  
19 this age group, this target group, to use  
20 photography, they become very literal at that  
21 point. They either like the way the hair looks or  
22 they would like the way the clothing looks, and  
23 that would get into the way of the message which  
24 is don't smoke.

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1           Also, as I pointed out here, most of  
2 these executions show somebody smoking, and we  
3 were not prepared to go out and do photography  
4 with an adolescent with a smoking cigarette in  
5 their hand. I think that would be subject to a  
6 great deal of criticism.

7           So the illustrations allowed us to  
8 allow the message to be central without dealing  
9 with some of those other issues.

10          Q.     Where were these posters used?

11          A.     They were used in and around schools  
12 and in classrooms themselves.

13          Q.     How did they get there?

14          A.     Well, we worked originally with some  
15 superintendents and principals of some school  
16 systems and showed them the materials, asked them  
17 if they would like to have to them as compliment  
18 or supplement to existing programs in the school.

19                 So we sent them these materials and the  
20 materials started to get placed in school systems  
21 around the country.

22          Q.     So the decision to put these materials  
23 into schools was not one which R.J. Reynolds  
24 Company made in the final analysis?

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1           A.       That's correct. We make the offer for  
2 the materials and they can either accept or  
3 decline them, and the decision is theirs as to  
4 whether or not to use them.

5           Q.       In addition to the posters, were there  
6 other materials as well?

7           A.       Yes. Things like table tent cards,  
8 something you would put in a cafeteria that had  
9 the same sort of message on it, book covers --  
10 kids use a lot of book covers -- with this message  
11 on it.

12          Q.       Okay. Any other materials which were  
13 used as part of the youth-directed nonsmoking  
14 program?

15          A.       Yes, and brochures that go into the  
16 schools every semester.

17          Q.       I think you had previously mentioned  
18 workbooks?

19          A.       Yes, workbooks that were for the  
20 teachers to interactively work with the students  
21 on a variety of subjects including nonsmoking.

22          Q.       Mr. Verner, let me show you what have  
23 you marked as Verner Deposition Exhibits 28, 29,  
24 30 and 31.

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1                   Would you describe those for the record  
2 or for the jury, please?

3           A.       Yes. These are Right Decisions Right  
4 Now booklets which are three-panel -- what are  
5 known as three-panel brochures.

6                   It talks about a variety of issues,  
7 about what's hot and what's not. There is always  
8 a celebrity story. In this case it's Melissa Joan  
9 Hart. That's the young lady that's on Clarissa  
10 Explains It All which is a very popular  
11 Nickelodeon program.

12                   Usually these celebrities will talk  
13 about a story on how they were able to make the  
14 right decision on something, whether it was to  
15 walk away from a situation where other kids were  
16 smoking or drinking or having a party when their  
17 parents were gone.

18                   Then there is a section that's called  
19 "My Story" where children are invited to write  
20 in, or I should say adolescents are invited to  
21 write in and tell a story about how they dealt  
22 with decision-making or peer pressure.

23                   And it talks about what's in and what's  
24 out, primarily because it's done in a way

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1 tohality-wise to really help them be interested in  
2 and be involved in it and to deliver the type of  
3 message that we wanted to.

4 Q. And, Mr. Verner, how were these  
5 brochures disseminated?

6 A. Same way. They were sent to the school  
7 systems and they were distributed to the  
8 classrooms as they see fit.

9 Q. Okay. So the school system made the  
10 decision whether or not the youth would be exposed  
11 to them?

12 A. Absolutely.

13 Q. Now, I meant to ask you, Mr. Verner,  
14 and so let me go back. With respect to these  
15 posters, you indicated that they were used in the  
16 school systems, and I wanted to ask you, are they  
17 also used elsewhere?

18 A. Yes. Well, for example, they were used  
19 and displayed at -- in billboards initially. We  
20 were running billboards in and around schools. We  
21 constructed signs on the school property in order  
22 to display this. We even used things like mobile  
23 billboards that were parked in the parking lot at  
24 schools in order to put this message in front of

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1 kids.

2 Q. Have they been used elsewhere, if not  
3 by Reynolds then nonetheless used?

4 A. I'm sorry. Can you say that again?

5 Q. Yes. Have these posters appeared  
6 elsewhere?

7 A. Oh, yes, absolutely. In fact, they  
8 show up on television programs. In fact, there is  
9 a number of the top 10 TV programs where these are  
10 used as props or as a backdrop in television  
11 programs where the situation is -- it fits,  
12 whether it's in a classroom environment.

13 Home Improvement is an example of a  
14 very popular TV program where these materials are  
15 posted, as it turns out to be in an emergency room  
16 because the guy is always hurting himself. So the  
17 ads appear in a number of places in addition to  
18 schools.

19 Q. Home Improvement is one of my favorite  
20 programs so --

21 A. They are on a roll right now.

22 Q. With respect to those brochures,  
23 Mr. Verner -- with respect to the brochures, they  
24 are issued through the schools on a once-a-year or

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1     what kind of a basis?

2             A.     Every semester they go into the  
3     schools.

4             Q.     So there are new materials which is  
5     available periodically?

6             A.     Yes. And you're dealing with middle  
7     schools and junior high schools, and most of the  
8     students are in there for either two or three  
9     years. And so a number of materials were  
10    developed so that as new people come rotating  
11    through, we have a combination of new materials as  
12    well as making sure that the kids aren't seeing  
13    the same things over and over again.

14            Q.     I think you indicated before that the  
15    brochures will typically contain some kind of  
16    commentary by a celebrity known to that age group?

17            A.     That's correct.

18            Q.     Can you give us some examples?

19            A.     Yes. The young lady that I mentioned  
20    in this one, Melissa Joan Hart, very popular  
21    Nickelodeon. Will Smith who plays the Fresh  
22    Prince of Bel-Aire was the first one, I believe,  
23    that was used in this program.

24            Q.     Okay. Now, Mr. Verner, let me show you

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1 what has been marked as Verner Exhibit 32. Can  
2 you tell me what that is?

3 A. Yes. I believe these are public  
4 service ads that were developed as part of the  
5 Right Decisions Right Now program that uses a lot  
6 of these celebrity testimonials in 15- or  
7 30-second spots that run on television  
8 programming.

9 Q. Mr. Verner, I would like to play that,  
10 if we can, for the jury. Perhaps we can air it  
11 here, but I expect we're going to have to have it  
12 at trial as well since I'm not sure if we can pick  
13 up on this camera the TV monitor.

14 A. Would you like me to?

15 Q. Yeah, why don't you.

16 (WHEREUPON, a videotape was played.)

17 BY MR. CRIST:

18 Q. I think that's finally it. Can you  
19 stop the tape?

20 A. This included some use of those PSAs at  
21 the Six Flags amusement park as well as the PSAs  
22 that were shown on TV.

23 Q. Okay. Thank you.

24 Mr. Verner, have there been any

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1 estimates made of the number of people who have  
2 seen these PSAs?

3 A. Yeah, absolutely.

4 Q. And can you tell us what those are?

5 A. Yeah. The terminology is known as  
6 gross impressions or the number of times that  
7 somebody or some people have seen it.

8 It's about 400 million of these PSAs  
9 that we just looked at here have aired about  
10 32,000 times.

11 Q. Have similar PSAs also been prepared  
12 for use on radio?

13 A. Yes.

14 Q. And about how many radio stations have  
15 they been distributed to?

16 A. Roughly about 6,500 radio stations with  
17 total audience base of about 370 million.

18 Q. And has the thrust of those radio PSAs  
19 been similar to go the television PSAs and the  
20 posters?

21 A. Very much so.

22 Q. Now, one of the things that you  
23 mentioned and the videotape showed was that the  
24 PSAs were also used at Six Flags?

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1           A.     Yes.

2           Q.     What are those?

3           A.     They are materials that actually go to  
4 the teachers that provide them posters and  
5 workbooks where they take the children or the  
6 adolescents through talk discussions, maybe  
7 role-play type of things, conflict resolution,  
8 making the right decisions, how to deal with peer  
9 pressure, warnings, things likes that.

10          Q.     Let me, Mr. Verner, show you what has  
11 been previously marked as Exhibits 33 through 38.  
12 Could you tell me what those are?

13          A.     Yes. These are an example of the  
14 materials that were developed in concert with  
15 Lifetime Learning Systems. It goes into the  
16 schools on the semesters, and I'll just show a  
17 little bit about what's in here.

18                 Each of them are themed really. In  
19 this case, this one happens to talk about conflict  
20 and how to resolve and how to deal with conflict.

21                 There is a teacher section in here that  
22 talks a little bit about the objectives of the  
23 exercise; sample questions, some role-playing,  
24 how to teach in this case students about how to

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1 A. Yes.

2 Q. And where at Six Flags?

3 A. When people were waiting in line during  
4 the summertime when it's very crowded, there are  
5 very long lines at Six Flags and other amusement  
6 parks, and on TV monitors that were there or in  
7 break areas, these PSAs were running, as well as  
8 distribution of caps and buttons that had to do  
9 with Right Decisions Right Now.

10 Q. Was it just at one of the Six Flags?

11 A. No, it was all.

12 Q. And when was that, do you remember?

13 A. I believe it was '95-'96 time frame.

14 Q. Perhaps might it have been 1993?

15 A. Pardon me?

16 Q. Might it have been 1993?

17 A. It could have been, yes.

18 Q. Has Reynolds done anything similar to  
19 the Six Flags program elsewhere?

20 A. Aladdin's Castle, video arcade, same  
21 types of programs.

22 Q. Now, you also mentioned, Mr. Verner,  
23 workbooks or school curricula supplements,  
24 correct?

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1 resolve conflict in a nonviolent way, on this  
2 particular one.

3 The posters that are used then that  
4 stay in the classroom during the time these  
5 particular things are being taught. And --

6 Q. Is there any reference on those  
7 materials to R.J. Reynolds Tobacco Company?

8 A. Yes. On the cover letter here, it --  
9 if you want me to read it, I can, but it  
10 references that it's part of the Right Decisions  
11 Right Now program.

12 It says "It is funded by R.J. Reynolds  
13 Tobacco Company which firmly believes that  
14 children should not smoke. The program was  
15 created for use with students in grades 6 through  
16 9 designed to help them to become more effective  
17 decision makers."

18 Q. Are any of the materials in there which  
19 are made available to students which identify R.J.  
20 Reynolds?

21 A. No. The letter identifies it for the  
22 teacher so there is no confusion where they're  
23 coming from, but the materials do not.

24 Q. Now, when you said these materials go

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1 into the schools, who then makes a decision with  
2 respect to whether these materials are used?

3 A. It would be the principal or the  
4 teachers, the public health administrator that  
5 might be resident in that school.

6 Q. Mr. Verner, what was the purpose of  
7 these materials? Were they supposed to supplant  
8 existing school curricula?

9 A. No. As I mentioned earlier, that the  
10 majority of what is going on in the schools during  
11 this time period was talking a lot about the risks  
12 and hazards associated with smoking.

13 Again, the literature and studies were  
14 showing that by getting more into the peer  
15 influence and peer pressure area, that that would  
16 be good. These are designed to compliment and  
17 supplement existing programs.

18 Q. Has Reynolds to your knowledge followed  
19 up with the schools to which these materials were  
20 sent to determine whether or not they were being  
21 used?

22 A. Yes, we have.

23 Q. And what have you been able to  
24 determine?

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1           A.       Very, very positive results. We  
2 surveyed principals and asked them, you know, how  
3 many times are threes materials being used, what  
4 percentage of the time. And we saw about a 90  
5 percent utilization of the materials which we were  
6 very happy with.

7           Q.       And 90 percent utilization at  
8 approximately how many schools?

9           A.       We are currently in about 7,000 middle  
10 or junior high schools, and they are estimating  
11 that there are a universe of about 10,000 to  
12 12,000. So in the neighborhood of 60 percent or  
13 more.

14          Q.       With respect to the focus of these  
15 materials, the posters, the brochures, the  
16 curricula, Mr. Verner, and the other materials  
17 that we have identified, and there were other  
18 materials. You identified tent cards before for  
19 example?

20          A.       Yes.

21          Q.       Table tents?

22          A.       Yes, same thing, table tents or tent  
23 cards.

24          Q.       I'm not sure I understand what the

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1 difference is -- what the precise terminology is.  
2 I've seen them, tent cards, at McDonalds, but I  
3 didn't know that's what they were called. So it's  
4 new terminology to me altogether.

5 Are there other organizations or  
6 entities which have used nonsmoking materials  
7 which did not make reference to -- strike that.  
8 Have PSAs been run by others with respect to youth  
9 nonsmoking programs?

10 A. Certainly.

11 Q. Have those PSAs developed by others  
12 always included references to the health risks or  
13 dangers associated with smoking?

14 A. No, not at all.

15 Q. Let me show you, Mr. Verner, what has  
16 been marked as Verner Deposition Exhibit 42 and  
17 ask if you can identify that?

18 A. Yeah. These are examples of public  
19 service ads that ran on television stations  
20 developed in some cases by public health  
21 organizations, whether it be national or state.  
22 And I believe this has several state public health  
23 agencies' materials on it.

24 Q. And do you remember which state health

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1 agencies were involved in preparing the PSAs  
2 included on that tape?

3 A. Yes. I believe that Minnesota  
4 Department of Health and Human Services or  
5 something like that, Minnesota Department of  
6 Health, and in fact there may in fact be a  
7 California Department of Health message on here.

8 Q. I would like to play that for the jury  
9 as well, Mr. Verner, if you would.

10 (WHEREUPON, a videotape was played.)

11 BY MR. CRIST:

12 Q. I think that's it, Mr. Verner. Maybe  
13 you can stop the tape.

14 None of those PSAs were among the  
15 Reynolds PSAs, is that correct?

16 A. No.

17 Q. Those were prepared by governments or  
18 others?

19 A. Yes, they were.

20 Q. That first one contained a spokesperson  
21 for it. Where was that obtained, do you remember?

22 A. Yes. This was obtained from, I  
23 believe it was on the A & E Network. There was a  
24 program on tobacco, and it was a clip of a very

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1 early ad that ran. It was back in the '60s, I  
2 believe, and the gentleman that was providing the  
3 editorial was the person that helped develop that  
4 ad.

5 Q. Were the PSAs of the kind which you  
6 have shown us here also tested, if not those  
7 precise ones, but were those kind of PSAs also  
8 tested in the focus groups?

9 A. Yes, they were.

10 Q. What was the reaction of those focus  
11 groups to those?

12 A. It depended on the ads. In some cases  
13 they liked it. And in other cases, they did not.  
14 An example, the last one on the reel here was seen  
15 by the respondents or by the kids as being very  
16 silly and unrealistic, depicting smoking and  
17 somebody that smoked in a very exaggerated manner.

18 And there is a fine line that one has  
19 to walk in terms of how you depict that. And in  
20 some cases they see it as relevant, but in that  
21 case, they didn't.

22 Q. Mr. Verner, I would now like to change  
23 gears, if we can, and turn to some of the  
24 parent-directed materials. Is that okay?

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1           A.       Sure.

2           Q.       And it's the second of the three  
3 elements, as I remember, that part of this  
4 program, there was the youth-directed,  
5 parent-directed and retailer-directed, is that  
6 correct?

7           A.       That's correct.

8           Q.       Let me show you, Mr. Verner, what have  
9 been marked as Verner Exhibits 43 --

10          MR. BEACH: Why don't we go off the record  
11 until we locate the correct exhibit.

12          THE VIDEOGRAPHER: Going off the video record  
13 at 3:13 p.m.

14                   (WHEREUPON, discussion was had  
15 off the record.)

16                   (WHEREUPON, a certain document  
17 was marked Verner Deposition  
18 Exhibit No. 43-A, for  
19 identification, as of 3-22-97.)

20          THE VIDEOGRAPHER: We're going back on the  
21 video record at 3:15 p.m. We are now going off  
22 the video record at tape No. 1 at 3:15 p.m.

23                   (WHEREUPON, discussion was had  
24 off the record.)

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1 THE VIDEOGRAPHER: We're going back on the  
2 video record at 3:17 p.m. at the beginning of tape  
3 No. 2.

4 BY MR. CRIST:

5 Q. Mr. Verner, I appreciate your patience  
6 while we straightened out our missing exhibit.  
7 Let me show you what have been marked as Verner  
8 Deposition Exhibits 43, 43-A and 44.

9 Could you identify those, please?

10 A. Yeah. Yes. These are examples of  
11 parent-directed materials, booklets and  
12 brochures.

13 Exhibit 43 is entitled "Choices,  
14 Helping Your Child Make The Right Ones, A Parent's  
15 Guide To Reducing The Risk of Negative Behavior in  
16 Adolescence."

17 Q. May I see that? Thank you.

18 A. 43-A is called "Tobacco, Helping Your  
19 Child Say No, A Parent's Guide to Helping Young  
20 People Make The Right Decisions," and 44 is  
21 entitled "How To Talk To Your Kids About Not  
22 Smoking Even If You Do."

23 And, again, these were all  
24 parent-directed materials that are designed to

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1 help parents do their part by encouraging them to  
2 have a dialogue with their child about not smoking  
3 and not doing a lot of other behavioral things  
4 that people in that age group tend to experiment  
5 with.

6 Q. Did the external affairs people at  
7 Reynolds also conduct marketing research with  
8 these to these materials?

9 A. Yes, absolutely.

10 Q. And what did you do?

11 A. Same sort of process, where, once  
12 again, develop the materials and you go out and  
13 show it to parents and you let them look at it and  
14 ask them to tell you what do you like, what don't  
15 you like and would you find it useful.

16 And the results were similar to what we  
17 saw before, which is parents like materials that  
18 give them some advice and help them prompt them on  
19 how to talk about sometimes what would be very  
20 difficult subjects with their children.

21 Q. And what were the conclusions of the  
22 parents to these materials in particular, if you  
23 know?

24 A. They liked them very well. They found

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1 them to be useful in having the decisions.

2 Q. Now, how are these materials made  
3 available to parents?

4 A. Through advertising, primarily. You  
5 can run billboards. We ran newspaper advertising  
6 with a toll free number where parents could call  
7 and request the information.

8 Q. And how much did they cost?

9 A. These materials?

10 Q. Yeah.

11 A. Nothing.

12 Q. What about the other materials that  
13 we've been talking about, how much did those cost?

14 A. Those are free of charge.

15 Q. Now, let's turn, if we can, Mr. Verner,  
16 to the third element of the Right Decisions Right  
17 Now program, the retailer-directed element.  
18 Okay?

19 Why did you develop that program?

20 A. Well, again, back around 1990 or so,  
21 there was a body of research that was starting to  
22 come out showing what the noncompliance rates were  
23 in terms of retailers selling cigarettes to people  
24 who were underage, and also at that time the

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1 emergence of some studies that indicated that if  
2 the retail age laws were complied with and  
3 enforced that that could make a significant  
4 difference in access and experimentation with  
5 kids.

6 So we looked at existing programs that  
7 were out there, met with retailers, met with trade  
8 associations and tried to come up with a way to  
9 expand some of the programs to help them.

10 Q. Now, I want to ask you about the trade  
11 associations in a second, but why were you  
12 focusing on retailers?

13 A. Because it was very important. The  
14 noncompliance rates that had been reported in some  
15 studies around that point in time indicated that  
16 unfortunately a large majority of the retailers  
17 would sell cigarettes to minors, and that's  
18 something we wanted to change.

19 Q. And with respect to the enforcement of  
20 those laws, was that also an element of the  
21 research which you conducted?

22 A. Yes. And, again, unfortunately not  
23 only were in many cases the -- or in most cases  
24 the compliance levels quite low, the enforcement

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1 was low to nonexistent as well.

2 So it was a dual combination that was  
3 occurring where people were not complying with the  
4 minimum age laws and they were not being enforced.

5 Q. Did your research tell you why it was  
6 that they weren't being enforced?

7 A. A lot of other conflicting priorities  
8 for particularly the local police departments.  
9 There were a lot of other things on their agenda,  
10 and this was not something they were paying  
11 attention to.

12 Q. And did you come to any conclusions  
13 with respect to the likelihood at the time you  
14 were doing this work about the probabilities of  
15 enhanced enforcement of the laws?

16 A. Well, again, if the local law  
17 enforcement agencies would in fact enforce the  
18 laws, that could really make a difference, but it  
19 starts with ensuring that the retailers themselves  
20 understand the law and can comply with it.

21 Q. Did you give a name to this part of the  
22 Right Decisions Right Now program, the  
23 retailer-directed part?

24 A. Yes, we did. We called it Support The

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1 Law, It Works.

2 Q. And what was the focus of the Support  
3 The Law, It Works program?

4 A. A couple really -- first of all,  
5 education, simply educating the retailers  
6 particularly the clerks as to what the minimum age  
7 laws were. And probably the most important  
8 component were training materials that were  
9 designed to allow the clerks to understand how to  
10 properly I.D., the importance of I.D.'g, how to  
11 engage in dialogue with somebody that maybe does  
12 not have an I.D. or has falsified their I.D.

13 Q. At the time you developed these Support  
14 The Law, It Works program, were there other  
15 programs by Reynolds or by the industry with  
16 respect to this?

17 A. Yes. The Tobacco Institute and the  
18 industry generally had a program called It's The  
19 Law, which was the predecessor to Support The Law.

20 Q. And what was the nature of the It's The  
21 Law program?

22 A. Again, primarily an educational program  
23 that was designed to communicate what the minimum  
24 age laws were to retailers and the importance of

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1 placing signage at retail that communicated that  
2 this was a store that supported the minimum age  
3 requirements.

4 Q. With the existing program through the  
5 Tobacco Institute, why did you decide to  
6 supplement that program?

7 A. Again, what we thought when we went and  
8 talked to some of the owners, store managers, we  
9 talked to trade associations and asked them what  
10 else can be done to help address this problem of  
11 noncompliance, they talked about the need in the  
12 retail environment where you have a lot of  
13 employees, the cashiers and the clerks that are  
14 constantly rotating through those stores, the need  
15 to educate them as to the law and how to properly  
16 age identify people.

17 So really what it was is it took it  
18 another level with a primary focus on the cashiers  
19 and how to train them.

20 Q. The people who were having the direct  
21 interaction with purchasers?

22 A. Absolutely. The store managers  
23 understand what the laws are, but, you know, the  
24 people who are actually selling the product are

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1 the people that needed to be trained more  
2 effectively on the nature of the law and the  
3 importance of compliance.

4 Q. Now, does Reynolds sell cigarettes at  
5 retail?

6 A. No, we don't.

7 Q. It's rather through various stores, is  
8 that right?

9 A. I beg your pardon?

10 Q. It's rather through various stores such  
11 as convenience stores and so forth?

12 A. Well, where people buy cigarettes,  
13 actually the store, the retailer themselves, sells  
14 the products to the consumer. We sell the product  
15 to a distributor.

16 Q. Now, prior to the It's The Law program  
17 and the Support The Law program, did any of these  
18 retail organizations themselves have programs to  
19 try to discourage youth smoking?

20 A. I'm not real familiar with the history  
21 in terms of what individual retailers were doing.  
22 I suspect there are certain large chains that  
23 perhaps have their own programs. But this was to  
24 the best of my knowledge the first coordinated

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1 effort that specifically emphasized training  
2 program materials.

3 Q. Let me show, Mr. Verner, what have been  
4 marked as Exhibits 45, 46 -- and perhaps I can ask  
5 to have this renumbered as 46-A -- 47, 48 and 49.

6 (WHEREUPON, a certain document  
7 was marked Verner Deposition  
8 Exhibit No. 46-A, for  
9 identification, as of 3-22-97.)

10 BY MR. CRIST:

11 Q. Would you please describe those  
12 materials for the jury?

13 A. Sure. These are programs or elements  
14 of the Support The Law It Works program that came  
15 in a large box or a packet that went out to the  
16 retailers and the trade associations.

17 Several pieces of materials including a  
18 brochure which is No. 45 that describes why they  
19 need to support the law, how they need to do it  
20 diplomatically, the importance of the use of  
21 signage to deter people from even asking for  
22 cigarettes, how to ask for I.D.s, in this case  
23 nicely but firmly. It goes through and  
24 articulates the importance there.

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1           It talks about the nature of all these  
2 program materials, the signage, the tear sheets  
3 and the rest of that. That's just an example of a  
4 brochure, and it has an order form here where they  
5 can order these materials in either English or  
6 Spanish in many cases.

7           Decals, door stickers. This is an  
8 example of something that was specifically asked  
9 for by many of the employees.

10          Q.     Could I see it, please?

11          A.     Yes. And it says here "Avoid selling  
12 age restricted products to underage consumers."  
13 And it talks about how to go about asking for it,  
14 visually check for the legal age. If doubtful,  
15 ask to see identification. If it's not  
16 satisfactory, do not make the sale. Be firm but  
17 polite. State it's the store's policy and remind  
18 them it's the law.

19               This policy asks, again, where there is  
20 this different age for tobacco and alcohol, and  
21 the ability to use a grease pen or pencil to put  
22 in what date the individual to have been born on  
23 to buy those products.

24               Importantly, a store policy

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1 acknowledgment where the employee is informed to  
2 read this, that they have gone through the  
3 materials and signed it stating that they  
4 understand what the law is and the store policy;  
5 other forms of signage.

6 In many cases some of them that were  
7 designed to dangle from the ceiling. And a  
8 videotape which was developed with the trade  
9 associations and an advertising agency to help  
10 train clerks on how to ask for I.D. and to resolve  
11 conflicts that may occur at retail.

12 Q. I would like to play that for the jury,  
13 Mr. Verner.

14 A. Sure.

15 (WHEREUPON, a videotape was played.)

16 BY MR. CRIST:

17 Q. Thank you, Mr. Verner. How were these  
18 materials made available to retailers?

19 A. Again, through advertising in  
20 newspapers or magazines, trade journals, industry  
21 trade journals as well as through the trade  
22 associations themselves.

23 Q. Okay. Were they also given to  
24 retail -- or to customers of Reynolds?

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1           A.     Yes. Our sales representatives had the  
2 program materials and put them in stores where  
3 they could.

4           Q.     Have Reynolds -- or did Reynolds take  
5 this program to any of the trade associations?

6           A.     Yes.

7           Q.     And specifically which ones do you  
8 recall?

9           A.     FMI, which stands for the Food  
10 Marketing Institute, the NACS or NACS or the  
11 National Association Of Convenience Stores which  
12 is a very large group that has places like 7-11 or  
13 Circle K, many of the very large convenience  
14 outlets, the National Association Of Chain Drug  
15 Stores. Again, the drug stores have their own  
16 trade association and many of them sell tobacco  
17 products.

18                         So we went to all of those trade  
19 associations. Even things like the Korean Grocer's  
20 Association, in order to present the materials to  
21 them, attempt to get their endorsement and have  
22 them help us distribute the program.

23           Q.     How were they received?

24           A.     Very well, very well. And they were

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1 involved in the development of the programs. So  
2 we were not surprised that they received them  
3 well.

4 Q. Now, when a chain of stores or an  
5 individual retailer for that matter decides he  
6 wants to use these materials, does Reynolds insist  
7 on any kind of a credit?

8 A. No. They can put their own logo on it  
9 if they want. It doesn't matter to Reynolds.  
10 There are some very large merchandisers that have  
11 their own internal employee training programs.  
12 Many of them have asked us if they can just have  
13 that and build that into their own program with  
14 their own logo, and that's fine.

15 Q. How many of the Support The Law  
16 materials were distributed?

17 A. 70,000.

18 Q. In addition to the distribution that  
19 Reynolds made through its own sales force and the  
20 distribution that Reynolds made through some of  
21 the large chains, what other form of distribution  
22 was there with respect to these material?

23 A. In some areas, local law enforcement  
24 agencies have played an active role in putting

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1       them out. The Jaycees also have been very vital  
2       in helping promote this program.

3       Q.       Has there been any research conducted  
4       with respect to the effectiveness of this program?

5       A.       Yes.

6       Q.       And can you tell us about that, please?

7       A.       Yes. Some years back we worked with a  
8       professor at the University of Colorado in  
9       Boulder, a gentleman by the name of John  
10      Lymberopoulos.

11      Q.       That's a tongue twister?

12      A.       I won't be able to spell it, but Dr.  
13      Lymberopoulos at the University of Colorado was  
14      retained by us to do a study which he designed and  
15      he interpreted which by working with law  
16      enforcement agencies in the Boulder and the Denver  
17      area, Dr. Lymberopoulos selected a number of  
18      stores to contain the Support The Law program and  
19      then other stores that did not have it.

20              And Dr. Lymberopoulos then employed  
21      through a talent agency people who were underage  
22      to go in to attempt to purchase cigarettes in the  
23      stores with and without, and he was then able to  
24      assess the compliance rate within the stores for

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1 those that had the Support The Law program versus  
2 those that did not.

3 Q. And what were his findings?

4 A. That in the stores that had the Support  
5 The Law program in it, there was a very  
6 significant decline over time in the percentage of  
7 those stores that were willing to sell cigarettes  
8 to minors.

9 So what he was able to demonstrate is  
10 that the presence of the materials in those stores  
11 made a material difference in the ability for  
12 somebody underage to come in and buy cigarettes.

13 Q. What's the current status of the  
14 Support The Law It Works program?

15 A. It has really been merged more into a  
16 Tobacco Institute program called We Card.

17 Q. So there is a new program which is  
18 taking the place of the Support The Law program?

19 A. Yes, yes, there is, and key components  
20 of the Support The Law program have now been  
21 incorporated into an overall industry and trade  
22 association effort.

23 Q. Let me show you, Mr. Verner, what has  
24 been marked as Exhibit 50 to this deposition.

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1 Would you identify what that package is, please?

2 A. Yes. It's a very large box called "We  
3 Card State Law Prohibits The Sale Of tobacco To  
4 Minors" and it's made available by the Coalition  
5 For Responsible Tobacco Retailing.

6 Q. Can you tell us, Mr. Verner, who is  
7 involved in the Coalition For Responsible Tobacco  
8 Retailing?

9 A. Combination of the manufacturers and  
10 the major trade associations.

11 Q. Major trade associations of --

12 A. Retail -- I'm sorry. Retail trade  
13 associations, the retailers that are responsible  
14 for selling the product.

15 Q. Could you explain to us what this We  
16 Card kit consists of?

17 A. Yes. There is quite a bit of materials  
18 in here. I'll summarize some of the key ones.  
19 Again, a training video cassette, training audio  
20 cassette. So in addition to the video we saw here  
21 there is another training program that is audio,  
22 window and door decals, pins, tear sheet pads.

23 For example, it's not uncommon to see  
24 in the store right now that if somebody comes in

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1 and does not have any age identification, the  
2 retailer can simply use this tear pad, give them  
3 this sheet of paper and say this is why I can't  
4 sell it to you.

5 It's very important to the retailers  
6 for a regular customer or somebody that's related  
7 to a regular customer to be able to go on the  
8 record as to why they are not making the sale.

9 A break room remainder card which is  
10 very similar to what I pointed out earlier, the  
11 importance of age identifying people and making  
12 sure their I.D. has not been altered in any way.

13 Counter signs, age of purchase  
14 calendars, employee training workbooks, a whole  
15 combination of materials.

16 For example, this one here "State law  
17 prohibits the sale of tobacco to minors. If you  
18 weren't born on today's date in 1979, you can't  
19 buy tobacco products."

20 Again, it helps the clerks very  
21 importantly to understand that this is a key date  
22 as it relates to cigarettes.

23 This program material here, I  
24 believe, -- I'm not sure this was done by state.

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1 So depending on the state, the materials may be  
2 different.

3 Q. What does the Coalition For Responsible  
4 Tobacco Retailing charge for these materials?

5 A. They are free of charge.

6 Q. To what extent have these materials  
7 been distributed to retailers throughout the  
8 country?

9 A. These have been very widely distributed  
10 with between 200,000 and 300,000 retail stores  
11 having these materials distributed to them which  
12 is a very large percentage of large stores that  
13 are out there. That is a very high penetration  
14 rate.

15 Q. What's the goal?

16 A. A hundred percent.

17 Q. How is it that these materials were  
18 distributed?

19 A. Combination through the trade  
20 associations themselves and a concerted effort  
21 with the manufacturers.

22 Q. Mr. Verner, we've described a number of  
23 activities over the course of the past 30 years  
24 that Reynolds and others have been involved with

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1 to try to discourage youth smoking, correct?

2 A. Yes.

3 Q. And in particular, we've discussed most  
4 completely today the three elements of the  
5 Reynolds Right Decision Right Now program, right?

6 A. That's correct.

7 Q. One portion of which has now been  
8 merged into the We Card program?

9 A. Yes.

10 Q. Mr. Verner, what is your view with  
11 respect to what effect the child-directed,  
12 parent-directed and retailer-directed efforts are  
13 likely to have on the incidence of youth smoking?

14 A. Well, they can if they are all done  
15 correctly and other people do their parts as well  
16 make a very significant difference.

17 When we developed these programs, we  
18 took a look at who is responsible for helping  
19 children not to smoke. And you look at what is  
20 the role and the responsibility of parents, what  
21 is the role and the responsibility of teachers in  
22 the school environment, what are the roles and  
23 responsibilities of the retailers in the retail  
24 trade environment.

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1           We believe that these programs are a  
2 very good faith effort to help assist other people  
3 do their jobs in talking to children about not  
4 smoking and not selling them cigarettes.

5           So all of these together fulfill a very  
6 important role that we believe that if they work  
7 in concert can make a very real difference in  
8 underage smoking.

9           MR. CRIST: Thank you, Mr. Verner. I have no  
10 further questions.

11          THE WITNESS: Thank you.

12          MR. CRIST: At this time, I would like to  
13 move into evidence those documents which were  
14 marked as Exhibits 1 through 50 that were  
15 discussed by Mr. Verner on the record. I believe  
16 there may have been a couple that we didn't  
17 actually reach, but I would move each of those  
18 into evidence, either substantive evidence or as  
19 appropriate demonstrative exhibits, and thank you  
20 very much.

21               Since the plaintiffs have decided not  
22 to attend today, I assume that any  
23 cross-examination which they might have has been  
24 waived by them. That concludes our deposition.

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1 Thank you.

2 (WHEREUPON, discussion was had  
3 off the record.)

4 MR. CRIST: Let's go off the record and  
5 discuss that.

6 THE VIDEOGRAPHER: Going off the record at  
7 3:46 p.m. at the end of tape No. 2.

8 (WHEREUPON, discussion was had  
9 off the record.)

10 THE VIDEOGRAPHER: We're going back on the  
11 video record at 3:53 p.m.

12 My name is Cary Davidow, the  
13 videographer. I certify that this videotaped  
14 deposition of Mr. Kevin Verner taking place this  
15 day is a complete and accurate recording of the  
16 on-record events of this deposition. I will  
17 supply a certificate of authenticity to be sent  
18 out with a copy of the video cassette. We are  
19 going off the video record at 3:54 p.m. at the end  
20 of tape No. 2.

21 FURTHER DEPONENT SAITH NOT.

22  
23  
24

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1 STATE OF MISSISSIPPI )

2 ) SS:

3 CQUNTY OF JACKSON )

4 IN THE CHANCERY COURT OF  
5 JACKSON COUNTY, MISSISSIPPI

6 IN RE MIKE MOORE, ATTORNEY GENERAL )

7 EX REL, STATE OF MISSISSIPPI ) Cause No.

8 TOBACCO LITIGATION, ) 94-1429

9 I hereby certify that I have read the  
10 foregoing transcript of my deposition given at the  
11 time and place aforesaid, consisting of Pages 1 to  
12 107, inclusive, and I do again subscribe and make  
13 oath that the same is a true, correct and complete  
14 transcript of my deposition so given as aforesaid,  
15 and includes changes, if any, so made by me.

16  
17 KEVIN VERNER

18 SUBSCRIBED AND SWORN TO

19 before me this day

20 of , A.D. 199 .

21  
22 Notary Public

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1 STATE OF ILLINOIS )

2 ) SS:

3 COUNTY OF C O O K )

4 I, SUSAN M. MARTINO, a Notary Public  
5 within and for the County of Cook, State of  
6 Illinois, and a Certified Shorthand Reporter,  
7 CSR No. 84-1990, of said state, do hereby certify:

8 That previous to the commencement of  
9 the examination of the witness, the witness was  
10 duly sworn to testify the whole truth concerning  
11 the matters herein;

12 That the foregoing deposition  
13 transcript was reported stenographically by me,  
14 was thereafter reduced to typewriting under my  
15 personal direction and constitutes a true record  
16 of the testimony given and the proceedings had;

17 That the said deposition was taken  
18 before me at the time and place specified;

19 That the reading and signing by the  
20 witness of the deposition transcript was agreed  
21 upon as stated herein;

22 That I am not a relative or employee or  
23 attorney or counsel, nor a relative or employee of  
24 such attorney or counsel for any of the parties

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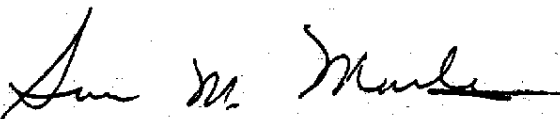
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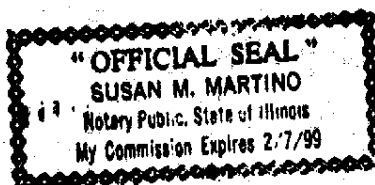
1 hereto, nor interested directly or indirectly in  
2 the outcome of this action.

3 IN WITNESS WHEREOF, I do hereunto set  
4 my hand and affix my seal of office at Chicago,  
5 Illinois, this 25<sup>th</sup> day of March, 1997.

6  
7   
8 Notary Public, Cook County,  
9 Illinois.

10 My commission expires 2/27/99.

11  
12  
13 C.S.R. Certificate No. 84-1990.



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## I N D E X

WITNESS

EXAMINATION

KEVIN VERNER

By Mr. Crist

3

## E X H I B I T S

NUMBER

MARKED FOR ID

Verner Deposition Exhibit

Nos. 1 through 57..... 3

No. 43-A..... 86

No. 46-A..... 95

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**KEVIN L. VERNER**

PERSONAL/CONFIDENTIAL MATERIAL REDACTED

**Business Experience**

**WMS Gaming Inc., Chicago, Illinois**

Feb. 1997 - Present

Vice President, General Manager

**R.J. REYNOLDS TOBACCO COMPANY, Winston-Salem, NC**

Dec. 1994 - Feb. 1997

Vice President - New Business Development

Feb. 1993 - Dec. 1994

Director - New Business Development

Aug. 1990 - Feb. 1993

Director - External Relations, Public Policy

1987 - 1990

Senior Brand Manager - Salem Brand

1986 - 1987

Brand Manager - New Product Development

1984 - 1986

Assistant Brand Manager - Winston Brand

1983 - 1984

Assistant Research Manager - Marketing Development

1982 - 1983

Sr. Marketing Research Analyst - Marketing Development

**CHAMPION SPARK PLUG CO., Toledo, OH**

July 1980 - Dec. 1981

Marketing Research Analyst

**Education**

August 1976 -  
April 1980

University of Michigan,  
Bachelor of Arts in Economics

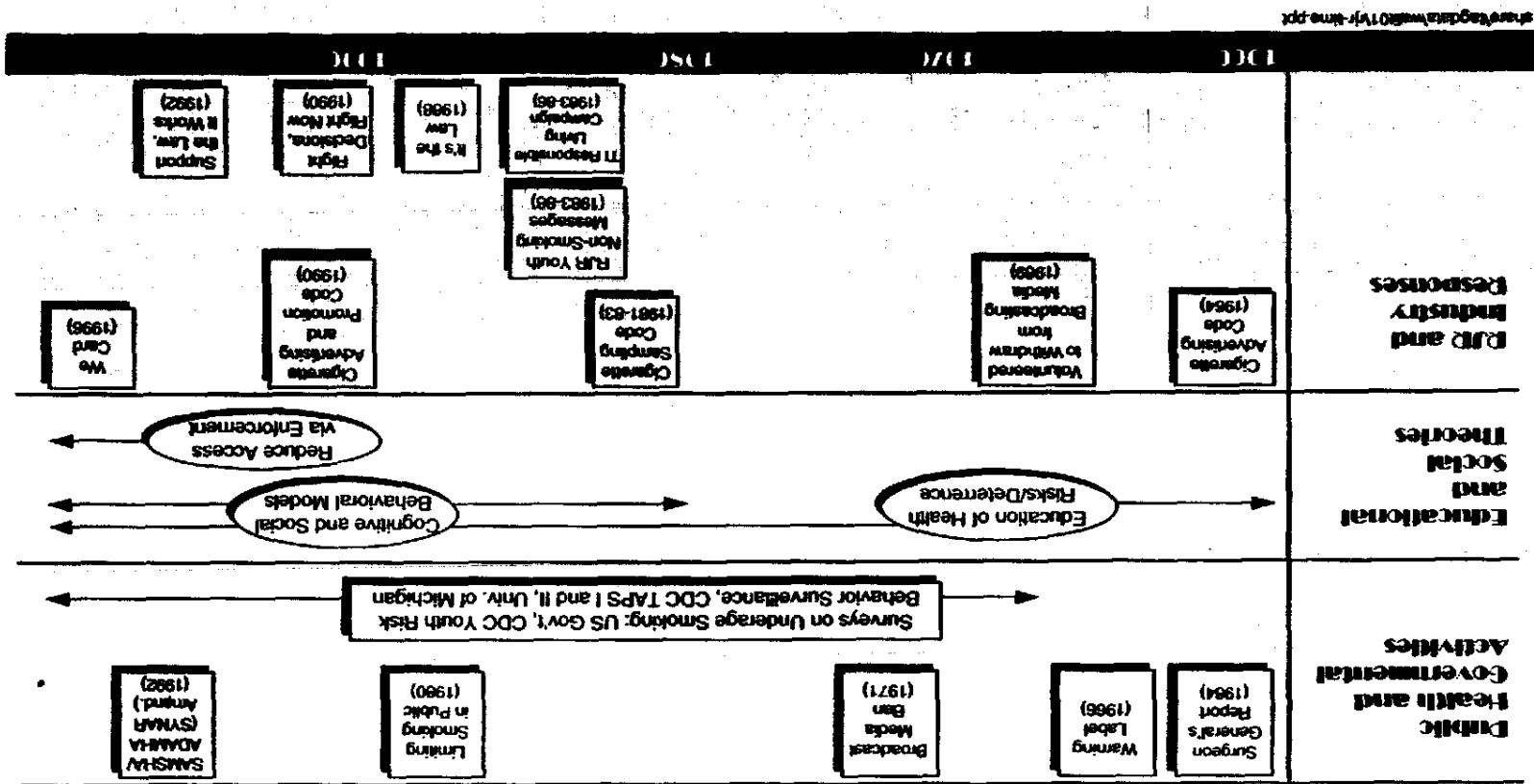
September 1980 -  
December 1981

University of Toledo,  
Graduate Studies in Econometrics/Statistics

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Verner DEP. EX. NO. 1  
FOR ID., AS OF 3-22-97 am

# History of RJR and TI Youth Non-Smoking Efforts/Programs



51604 5768

3-22-97  
Lester  
3-22-97

# CIGARETTE ADVERTISING CODE

## ARTICLE IV, ADVERTISING STANDARDS (1964)

### Advertising Placement Restrictions:

- No advertising during television programs or in publications not directed primarily to persons 21 and older
- No advertising in school, college or university media
- No advertising in comic books/comic supplements in newspapers

### Advertising Content Restrictions:

- Advertising cannot represent that smoking is essential to social prominence, distinction, success or sexual attraction
- Natural/fictitious persons depicted in advertising shall be at least 25, and not be made to appear to be less than 25
- Use of attractive, healthy looking models is permissible, so long as there is no suggestion that their attractive appearance or good health is due to smoking
- Advertising cannot depict smoking in an exaggerated manner
- Advertising cannot depict as person well known as an athlete
- Advertising cannot depict a smoker as participating in, or obviously having just participated in, physical activity requiring stamina beyond that of normal recreation

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## Advertising Content Restrictions (cont'd):

- No testimonials from athletes or celebrities in the entertainment world
- Generally, no representation with respect to health
- Generally, no representation with respect to use of filter to remove certain smoke constituents

## Product Sampling:

- Samples shall not be distributed to persons under age 21
- No distribution of product samples on school, university or college campuses

# CODE OF CIGARETTE SAMPLING PRACTICES (1983)

## Restrictions on Distribution of Samples:

- No samples to persons under age 21
- No sampling in public places within two blocks of any center of youth activities (such as playgrounds, schools, college campuses or fraternity/sorority houses)
- No unsolicited samples may be sent through the mail
- No samples may be distributed to a person in a vehicle

## Restrictions on Persons Conducting Sampling:

- Persons conducting sampling shall not urge any adult aged 21 or older to accept a sample if the adult declines to accept it
- Persons conducting sampling shall indicate that samples are intended only for smokers
- Persons conducting sampling must secure their stock of samples in safe locations
- Persons conducting sampling must avoid impairing the flow of traffic
- Persons conducting sampling must dispose of litter in the immediate vicinity of the sampling activity

## Termination of Sampling:

- In the event circumstances arise making it unlikely that sampling can occur in accordance with the requirements of this Code, sampling must cease until such circumstances abate

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# CIGARETTE ADVERTISING & PROMOTION CODE (1990)

## Restrictions on Advertising Placement:

- Advertising shall not appear in publications directed primarily to persons under age 21 (including school, college or university media)
- Advertising shall not appear on billboards within 500 feet of any elementary, junior high school, high school, or playground

## Restrictions on Advertising Content:

- No one depicted in an advertisement shall be or appear to be under age 25
- Advertising shall not suggest that smoking is essential to social prominence, distinction, success or sexual attraction, nor shall it picture a person smoking in an exaggerated manner
- Advertising may use attractive, healthy looking persons, provided there is no suggestion that their attractiveness and good health is due to cigarette smoking
- Advertising cannot depict as person well known as an athlete
- Advertising cannot depict a smoker as participating in, or obviously having just participated in, physical activity requiring stamina beyond that of normal recreation

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- No sports or celebrity testimonials shall be used or those of others who would have special appeal to persons under age 21
- No payment may be made for placement of any cigarette (product or advertisement) as a prop in any movie produced for viewing by the general public

### Restrictions on Product Sampling:

- No samples to persons known to be under age 21 or who, without reasonable identification, appears to be less than 21
- Sampling shall not be conducted on in or on public streets, sidewalks or parks, except in places that are open only to persons to whom cigarettes may be lawfully sold
- Sampling shall not be conducted in any public place within two blocks of any centers of youth activities (such as playgrounds, schools, college campuses, or fraternity/sorority houses)
- Unsolicited samples shall not be sent through the mail
- Samples shall not be distributed by mail without written, signed certification that the recipient is 21, a smokers, and wishes to receive a product sample
- Persons engaged in sampling shall not urge any adult aged 21 and older to accept a sample if the adult declines or refuses to accept such sample
- Persons conducting sampling shall indicate that samples are intended only for smokers

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- Persons conducting sampling must secure their stock of samples in safe locations
- Persons conducting sampling must avoid impairing the flow of traffic
- Persons conducting sampling must dispose of litter in the immediate vicinity of the sampling activity
- In the event circumstances arise making it unlikely that sampling can occur in accordance with the requirements of this Code, sampling must cease until such circumstances abate
- Contracts with persons conducting sampling must require adherence to the sampling provisions of this Code
- Persons engaged in sampling must be monitored on a periodic basis by the manufacturer
- Manufacturers must take all reasonable steps to ensure that a person who knowingly engages in sampling in a manner contrary to the sampling provisions of the Code shall be discharged

## Restrictions on Other Promotional Activities:

- No distribution of non-tobacco premium items bearing cigarette brand names, logos, etc. without written, signed certification that the addressee is 21 or older, a smoker, and wishes to receive the premium
- There shall be no other distribution of non-tobacco premium items bearing cigarette brand names, logos, etc., except with the purchase of a cigarette to persons 21 or older

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- Clothing bearing cigarette brand names or logos shall only be in adult sizes
- Samples shall not be distributed on the basis of phone requests

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# Some straight talk about smoking for young people.

We're R.J. Reynolds Tobacco, and we're urging you not to smoke.

We're saying this because, throughout the world, smoking has always been an adult custom. And because today, even among adults, smoking is controversial.

Your first reaction might be to ignore this advice. Maybe you feel we're talking to you as if you were a child. And you probably don't think of yourself that way.

But just because you're no longer a child doesn't mean you're already an adult. And if you take up smoking just to prove you're not a kid, you're kidding yourself.

So please don't smoke. You'll have plenty of time as an adult to decide whether smoking is right for you.

That's about as straight as we can put it.

R.J. Reynolds Tobacco Company

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# Does smoking really make you look more grown up?

It's a crazy world.

Most adults we know would love to look younger than they really are. While most young people are busy trying to look more adult.

This is one reason why many young people take up smoking.

Well, we wish they wouldn't.

For one thing, it doesn't work. A fifteen-year-old smoking a cigarette looks like nothing more or less than a fifteen-year-old smoking a cigarette.

Even though we're a tobacco company, we don't think young people should smoke. There is plenty of time later on to think about whether or not smoking is right for you.

Besides, when you think about it, being grown up is highly overrated. You have to go to work, pay taxes, wear normal clothes and raise kids who grow up to be teenagers.

Why be in such a hurry?

R.J. Reynolds Tobacco Company

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# How to handle peer pressure.

If some of your friends smoke, and they make you feel like you should smoke, too, that's "peer pressure."

But even though we're a cigarette company, we think young people shouldn't smoke. Even the decision to smoke or not to smoke should wait until you're an adult.

So we put together these ideas to help you recognize peer pressure—and resist it.

- |                   |  |
|-------------------|--|
| <b>Tactic #1:</b> | <i>Go ahead and take a puff—what's the matter, are you chicken?</i>  |
| <b>Answer:</b>    | You must think I'm pretty dumb to fall for that one. It takes a lot more guts to do your own thing than to just go along with the crowd. |
| <b>Tactic #2:</b> | <i>Come on, all the cool kids smoke.</i>   |
| <b>Answer:</b>    | Maybe the kids who smoke are trying to look cool. But if they really <del>were</del> cool, maybe they wouldn't have to try so hard.      |
| <b>Tactic #3:</b> | <i>Hey, I'm your friend—would I steer you wrong?</i>   |
| <b>Answer:</b>    | Friends are people who like you for who you are, not for what they want you to be. If you're really my friend, back off.                 |
| <b>Tactic #4:</b> | <i>Do you want everybody to think you're a nerd?</i>   |
| <b>Answer:</b>    | Sure I care what other kids think of me. But if they base their opinions on stuff like smoking, their opinions aren't worth much.        |
| <b>Tactic #5:</b> | <i>I bet you're just scared your parents will find out.</i>  |
| <b>Answer:</b>    | I wouldn't blame my parents for getting teed off. How can I expect them to treat me like an adult if I sneak around and act like a kid?  |

It's natural for you to want to be just like your friends.  
But if you don't smoke, maybe your friends will want to be just like you.

© 1984 R. J. REYNOLDS TOBACCO CO.

R. J. Reynolds Tobacco Company

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# Some surprising advice to young people from RJ Reynolds Tobacco.

Don't smoke.

For one thing, smoking has always been an adult custom. And even for adults, smoking has become very controversial.

So even though we're a tobacco company, we don't think it's a good idea for young people to smoke.

Now, we know that giving this kind of advice to young people can sometimes backfire.

But if you take up smoking just to prove you're an adult, you're really proving just the opposite.

Because deciding to smoke or not to smoke is something you should do when you don't have anything to prove.

Think it over.

After all, you may not be old enough to smoke. But you're old enough to think.

R.J. Reynolds Tobacco Company

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# Helping Youth Decide



A new program for parents developed by the National Association of State Boards of Education

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**T**he 600 citizen volunteer members of the National Association of State Boards of Education (NASBE) provide policy-making leadership to public education in the United States. Their efforts are designed to assure quality education to every child in every classroom in the states and territories.

As education leaders, state board members recognize that a partnership exists among schools, parents and communities. This publication is an example of two of these, education and business, reaching out to the third, parents.

NASBE is proud of *Helping Youth Decide*. We believe the booklet meets a crucial need of parents. We have received hundreds of letters of thanks from parents, education and social welfare professionals and others who have found it useful and instructive.

A half million copies of the first, 1984, edition have been distributed, on request, to individuals and groups. A Spanish version, *Decidiendo Juntos*, is also available from NASBE.

We hope that parents who use these guides will find them useful in establishing effective parent-child communication and in helping children learn to make sound decisions. NASBE believes that sound communication and decision-making skills are critical to every child's journey toward responsible adulthood.

January 1986  
Second Edition

Phyllis Blaunstein  
Executive Director  
National Association of  
State Boards of Education

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NASBE, a nonprofit organization, accepts outside funding for educational projects. It does not, however, endorse the products of any sponsor.

Publication and free distribution of *Helping Youth Decide* was made possible by The Tobacco Institute, Washington, D.C., an association of cigarette manufacturers who as a matter of longtime policy and practice believe that young people should not smoke. It is the Institute's hope that this booklet will help parents deal with the full range of decisions adolescents face today.

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# Introduction

**C**hild raising has been a subject of debate among adults as long as there have been children. Almost every parent has opinions, or has heard theories about one of the most tenuous and difficult of family relationships: that between parent and adolescent.

You've probably said it yourself a hundred times. And you're right. Raising an adolescent is hard on the parent. But adolescence can be even more difficult for the youngster, who is trying to make the transition to young adulthood and is not quite sure how to handle it.

This is the time when your young teenager will be faced with many new decisions. Some decisions will be small, others important. Consider the following examples: how to dress . . . whom to choose as friends . . . whether to quit school . . . go to college . . . when to begin dating . . . whether to take a job.

Making responsible decisions is a skill that is best learned with the help of someone more experienced. With adult help, youngsters are more likely to make good choices.

Shared decision making begins with good communication between parent and child. Good communication skills help to strengthen the mutual respect and trust in the family. It is the objective of this booklet to help family members better understand each other, talk more easily and effectively to each other, and make more responsible decisions that are more agreeable to both parent and child.

This booklet is divided into three parts. Part I discusses what's involved for you and your child during the adolescent years. Part II suggests ways to develop more open lines of communication with your teenagers and to guide them in decision making. Part III includes materials designed to help you implement the ideas presented in the preceding sections—some "homework" for parent and child.

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# Part 1 Growing Pains

**M**ark Twain wrote that at age 17 he thought his father the most ignorant man who ever lived, but at age 21 he was amazed at how much the old man had learned in four short years.

What we call the generation gap isn't anything new. Throughout history, teenagers—no longer children, but not yet adults—have questioned the rules laid down by their parents and by society.



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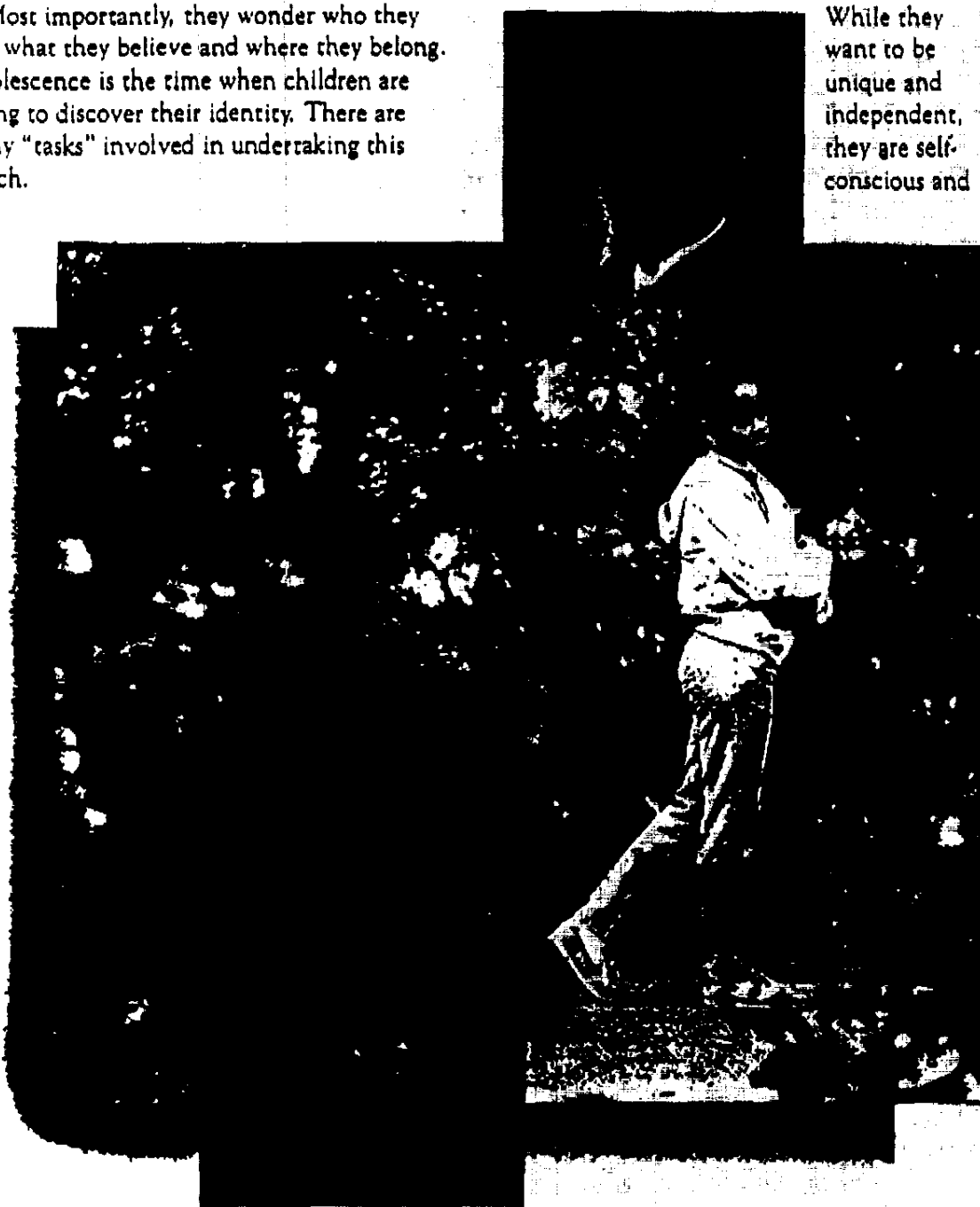
Questioning authority, testing the rules and experimenting with adult behaviors are all a natural part of adolescent growth. Youngsters want freedom, yet freedom is frightening. There are new feelings to contend with. Biological and emotional changes are taking place within that young teens do not fully understand.

Most importantly, they wonder who they are, what they believe and where they belong. Adolescence is the time when children are trying to discover their identity. There are many "tasks" involved in undertaking this search.

For the first time, young persons are beginning to look toward the future and to try to fit it with the past and present. They often have great dreams and become very idealistic. This hopefulness is one way they begin to feel some control over their destiny.

Young teenagers are trying to arrive at a clear sense of their own feelings and beliefs.

While they want to be unique and independent, they are self-conscious and



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afraid of being "different." As a result, young teens often dress and act like their friends, the sense of security thus attained allowing them to search for and test new and different beliefs and behaviors.

Adolescence is a time of experimenting and testing. Young people try out different behaviors and take risks and learn from reactions of family and friends. Thus they find out what their abilities, interests and responsibilities are.

Teenagers are also facing the eventuality of leaving home and joining a working society. They must mesh their interests, skills, and talents with the duties, jobs and roles available to them. They often feel a sense of

inadequacy and may underestimate themselves. They need to experiment and compete in work and play to discover where they fit in.

As young people become more sure of who they are and more confident of themselves,



they can begin to share more of their hopes and fears with others, especially their peers. It is normal for adolescents to begin shifting some of their



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emotional dependency from their parents to their friends.

They will also begin to define more clearly their relationships with others. Whom they will follow and whom they will lead become important decisions. By beginning to develop a responsibility toward younger friends and neighbors they are preparing for the adult role of guiding and teaching others.

Finally, adolescents are beginning to narrow and deepen their interests. Instead of a passing interest in many things, they begin to develop a deeper interest in a few ideas and activities.

Young people are undertaking a search for their identity within a confusing array of choices and challenges. Their world is no longer the grade-schooler's simple and secure environment, protected by parents and teachers.

In junior and senior high school, teachers are more challenging and the subjects more difficult. There's more competition for the attention and approval of classmates . . .

increased expectations of parents and teachers . . . new extracurricular activities.

In earlier times, the institutions of family, neighborhood and community provided stability that could help young people safely through the "growing up" process. Now society is increasingly fragmented and television has introduced children to all aspects of adult life.

Thus, communication between parents and their children has become more crucial.

Young people need support and advice on how successfully to manage the "work" of the adolescent years.

Experiencing growing pains as they verge on maturity, adolescents also need gradual, reasonable preparation for making their own decisions. This includes opportunities to discuss with parents, as well as their peers, what their choices are and the possible consequences of their actions. In the following section we will discuss the various aspects of communications skills and responsible decision making.



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# Part 2

## How to Help

**G**ood communication within the family is the foundation for the mutual trust that encourages responsibility. When parents and children are able to communicate well, they find it's much easier to resolve conflicts and to arrive at mutually agreeable decisions.

To communicate effectively, parents need to express accurately to their children their own ideas and feelings as well as to listen to and understand the youngster's thoughts and emotions. Adolescents, even more than younger children, need

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someone who will listen. They need a sounding board off which to bounce developing ideas, and they need someone with whom to talk out their problems.

## How Not to Communicate

Good communication is particularly difficult when one person has a problem or is in a bad mood. Frequently,

instead of listening, parents react with responses that block communication.

For instance:

*Typical Response*

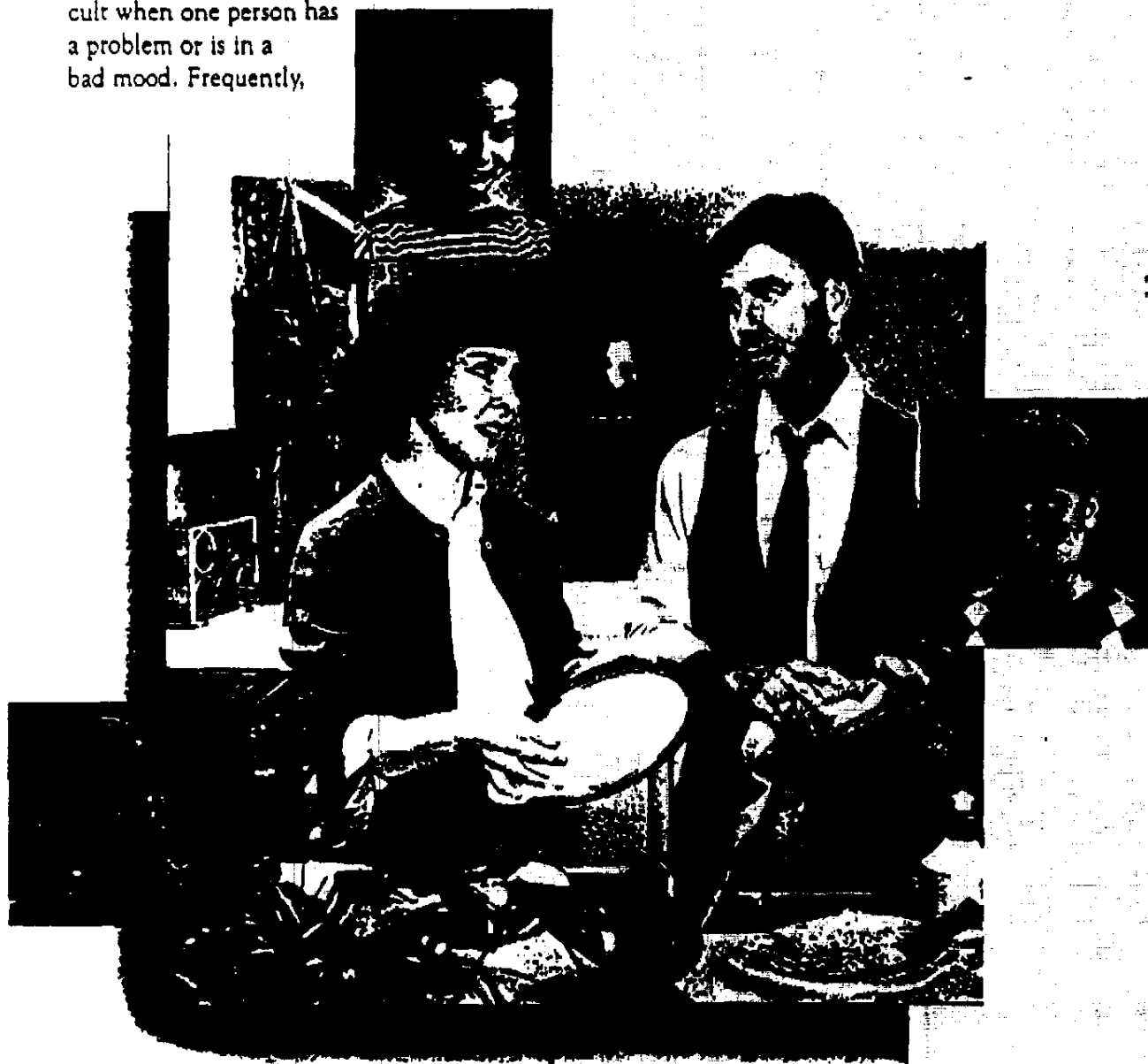
**Threatening**

"If you don't, then. . ."

"You'd better, or. . ."

*Possible Reaction*

*Invites testing of threatened consequences, anger, rebellion.*



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*Typical Response*

**Preaching**

"You should have. . ."

"It is your responsibility. . ."

"You ought to. . ."

*Possible Reaction*

Communicates lack of trust in child's sense of responsibility.

*Typical Response*

**Blaming**

"You are lazy."

"You are not thinking maturely."

*Possible Reaction*

Cuts off communication from child over fear of being criticized.

*Typical Response*

**Analyzing**

"What's wrong with you is. . ."

"You're just tired."

"You don't really mean that."

*Possible Reaction*

Stops communication as child fears being misunderstood or exposed.

*Typical Response*

**Pacifying**

"Oh, cheer up."

"It's not so bad!"

*Possible Reaction*

Makes child feel misunderstood, angry, confused.

*Typical Response*

**Probing**

"Why did you do that?"

"Who was there with you?"

"Exactly what did you say?"

*Possible Reaction*

Provokes anxiety, withdrawal, half truths to avoid criticism.



*Typical Response*

**Avoiding**

"Let's talk about pleasant things."

Remaining silent, turning away.

*Possible Reaction*

Implies child's problems are unimportant, discouraging openness.

One of the best ways parents can avoid these typical responses is to concentrate more on listening. When parents listen with interest, children feel their ideas are valued.

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that they are respected. Such respect gives the child a sense of self-esteem and confidence as the child reasons, "If my parents believe I'm worth listening to, I must be a person of value and importance."

## Listen- So They'll Talk

Listening is an art that requires practice. Here are some ideas to help you become a better listener, for your child's sake.

**Be attentive.** Stop what you're doing as soon as you can and give full attention. Focus fully on your child's words, using eyes as well as ears. A youngster may say nothing is wrong when dejected looks tell you differently. So be sensitive to tone of voice and expression. Ask yourself what your child is trying to tell you.

**Encourage talk.** Eye contact, a smile, a nod and one-word responses indicate understanding if not agreement. Keep questions brief, open and friendly, but try to avoid "why" questions. Children don't always know all the reasons behind their actions and feelings and open-ended questions won't help.



Often, repeating an important idea your young teen has expressed, but in a tentative way, draws the child out. "It sounds like your feelings were hurt when she said that." "You must feel very proud to have done that. Am I right?"

**Try to empathize.** Understanding others begins with empathy, putting oneself into their shoes, as we will see in an exercise in Part III. Empathizing with the adolescent takes imagination and patience. But try to focus on underlying feelings your youngster may be finding difficult to express. Demonstrating empathy helps you both understand the youngster's actions and reactions better.

**Listen with respect.** React to your child as you would to an adult friend. Grownups tend to do most of the talking when conversing with young people. Listen as much as you talk.

After speaking for half a minute or so, stop and let your youngster have a chance.

And accept the fact adolescents are complainers. Let them get their grievances off their chests. Try not to interrupt or push a topic they don't want to discuss.

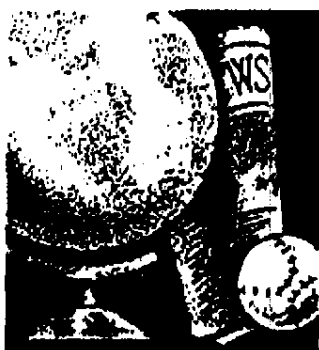
Listening is certainly one of the most important skills of parenthood. It builds closeness. It also helps young people release pent-up emotions and strengthens their ability to make decisions and solve their own problems.



# Talk- So They'll Listen

Take time to have relaxed conversations alone with each of your children on a regular basis, five or 10 minutes each day. Frequent talks will help you spot difficulties before they become real problems.

So often when parents talk to their youngsters, they correct, criticize or command. Though we may occasionally need to direct behavior, the conversation should be enjoyable for both parent and child. We should also



have talks about world events and reading, sports and movies, science and religion, thoughts and feelings. In open discussions, various points of view are expressed and

everyone both talks and listens. It is often helpful to be *doing* something together when you talk—and preferably when others are not around.

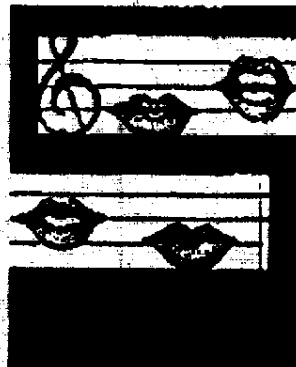
Here are some specific guidelines for talking with adolescents.

**Show respect.** As you did in listening, so in talking. Show your young teenager the same courtesy and interest you would show your adult friends.

**Be brief.** The time to stop talking is before your youngster stops listening. If you must get across a message, feed a little information—remember the half-minute rule for good listening?—then ask for comment before adding a little more. Try not to lecture.

**Be aware of your tone of voice.** Often it's not what you say but how you say it that conveys your message—how loudly, softly, fast or slowly you speak.

You also communicate with eye contact and facial expression.



**Be specific.** Strive consciously to communicate in simple and specific terms.

For instance, instead of "I wish you didn't look so sloppy," say "I'll treat you to a haircut Saturday." Instead of "We'll go to the pool together soon," specify "Let's go swimming this weekend."

And, lastly, help your youngster empathize with you by expressing your feelings. Reveal some of your inner self. Let your youngster know you also are an individual and can be hurt by others, even confused in your thinking and fearful of certain situations.

Emphasize your feelings, not their behavior.

Don't say: "You should be helping me with dinner and the dishes. You're so lazy and inconsiderate sometimes."  
(*"You" message*)

Do say: "I get so angry when I get stuck doing all this work by myself."  
(*"I" message*)

Don't say: "Your room is such a mess. How can you live like that?"  
(*"You" message*)

Do say: "When I see clothes spread all over the floor, I am furious. I feel like throwing the whole mess into the trash." (*"I" message*)

*"You" messages tend to cast blame, lower self-esteem, harm the relationship and fail to change behavior in the long run. "I" messages tell others how we feel, state the problem and how it affects us, do not threaten, and tend both to help the relationship and change behavior.*

By adopting better ways of talking and listening, parents accomplish a lot toward educating their children for responsibility. Young teens are in transition, preparing for a time when they will have to be more independent. Good communication builds good relationships and is the best foundation for helping

our young teenagers learn to make more of their own decisions.

## Responsible Decision Making

Children and adolescents need the opportunity to practice making decisions in order to become self-directed, critical thinkers. They need the opportunity to learn that sometimes postponing a decision is a decision in itself.

When parents make all decisions, children tend to see their lives as controlled by others. Then they are not likely to attempt decision making when they reach adolescence. Adults who suggest and help, rather than direct and decide, are more likely to instill the confidence adolescents need to make more and more independent decisions.



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Young people need opportunities to examine the potential consequences of choices, to choose and to accept the responsibility for the choices they make.

Here are steps you can follow to teach responsible decision making.

1. **Acknowledge the facts.** Adolescents are faced with choices that can affect their lives. Tell them you know they have important decisions to make, that some are very difficult and that the consequences are not always easy to accept.
2. **Clarify the issue.** Make sure you are both talking about the same thing, that you have the same concerns.
3. **Gather and examine current information.** Many of our beliefs, our opinions, are based on bits and pieces of information. It is important that we gather the facts relevant to a given issue. With information at hand, we can more appropriately filter out conflicting messages, separate fact from fiction and make constructive choices.
4. **Look at alternative courses of action.** Make a list together of all the possible choices presented by the situation at hand. Write down everything either of you thinks of, even if it seems silly or unacceptable. The process of elimination will follow. At this stage, however, it is important to include every idea.
5. **Examine the likely consequences.** Ask the question, "What are the expected consequences of a given decision?" Then compile a list of the pros and cons. The pros,



for example, might include friends' approval, having fun, feeling grown-up or appearing independent. It is important to acknowledge what a young person might enjoy about the behavior, even though some of the supposed pros may not be desirable—or acceptable—by others' standards at any age.

6. **Discuss feelings, beliefs and moral considerations.** After you have looked at the pros and cons of a decision, encourage an examination of feelings, values, beliefs. This might be done by sharing your own feelings and beliefs, along with your thoughts when you made a somewhat similar decision. What have been your feelings when you have faced such choices—and why? Discuss them.

Your honesty can be powerful. Perhaps you regret a decision you once made, ignoring your own beliefs or instincts in order to feel more accepted, to go along with the crowd. How did you end up feeling—and why?

Discuss family values and moral considerations. What experiences have you had or heard about, what values do you believe this violates or promotes—and why?

Remember that this technique may backfire if you preach. This approach is designed to help youth explore and develop their *own* values and morals, to be honest with themselves about how they really feel. Respect their feelings by encouraging open and honest examination. Try not to condemn them or their feelings. To do so encourages resistance to you and your values.

7. *Discuss what our society considers acceptable behavior.* Young teens are well acquainted with their own peer group standards. They may not be so familiar with those of society as a whole and are likely to dismiss what they perceive as society's principles as arbitrary or old-fashioned.

As a representative of adult society, you can outline what is expected of its members, for example, responsibility for debts

and other financial obligations, consideration of others, responsibility for one's own actions. At this point, you might discuss legal restrictions, to show that society holds some beliefs so strongly it is willing to use various sanctions to enforce them.

8. *Decide on the best possible course of action.* Having discussed all of the relevant facts, the various alternatives, the consequences of each of the possible choices and everyone's feelings and beliefs, you and your youngster are now ready to make a decision. And keep in mind this may involve compromise.

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## A Voice and a Choice

These suggestions are designed to guide you in helping your adolescent develop sound decision-making skills. They are not meant to be used in their entirety in all situations.

Their application is up to you.

The responsible decision-making goal is to give youngsters a voice and—when appropriate—a choice, in matters that affect them. The primary purpose of this booklet is to help you in directing the participation of your children in those matters which affect their lives.



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# Part 3 Homework for You Both

**T**he preceding sections have offered some insights into the adolescent world and have provided concrete guidelines for (1) improving communications between parents and adolescents and (2) helping parents help their children develop decision-making skills. This third and final section contains parent and youth questionnaires and some exercises to help you establish more open communication with your young teenagers to guide them toward responsible decision making.

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# Parent and Youth Questionnaires

In the back of this booklet are two questionnaires. These—and some of the exercises that follow—may seem a bit unusual. However, trying something out of the ordinary can often help to see a situation in a new and different light.

The questionnaires should be separated and answered independently by each of you. It is important that you neither discuss the questions nor compare your answers until both are through.

Please do not read further until both have answered all the questions.



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## Scorecard for Parent and Youth Questionnaires

Question #	Code	Question #	Code
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

"+" means parent and child agree and are satisfied. "-" means they agree but are not satisfied. "0" means they disagree.

Now you are ready to compare answers. Place the completed questionnaires side by side. With the chart above, look for three things:

1. When your answers agree and you are both happy with the situation, mark a plus sign (+) in the code column on the chart. Example: If you both agree, on question 3, that permission is usually granted because of parental trust, write "+" in the code column.
2. Some of your answers may agree but neither of you is happy about the situation. Enter a minus sign (-) in the code column. Example: You both agree, on question 3, that the parent usually questions the child. The parent would rather be trusting, the teenager would rather be trusted. So you enter "-" in the code column.

3. Your answers do not agree. Mark these questions with a zero (0).

What does the completed chart mean? The questions you labeled "+" point to areas of your relationship that are strong. *Build from these strengths.*

The questions labeled "-" indicate problems you are both aware of but would like to improve. That you are aware of a need for change is an advantage. *You can concentrate on possible solutions.*

The questions labeled "0" may be the toughest to resolve, because the two of you do not agree on the problem. Depending on the question and on your answers, *try to decide how important each is* and discuss some compromise solutions. If differences are significant or if you have difficulties, consider seeking the advice of someone you both trust.

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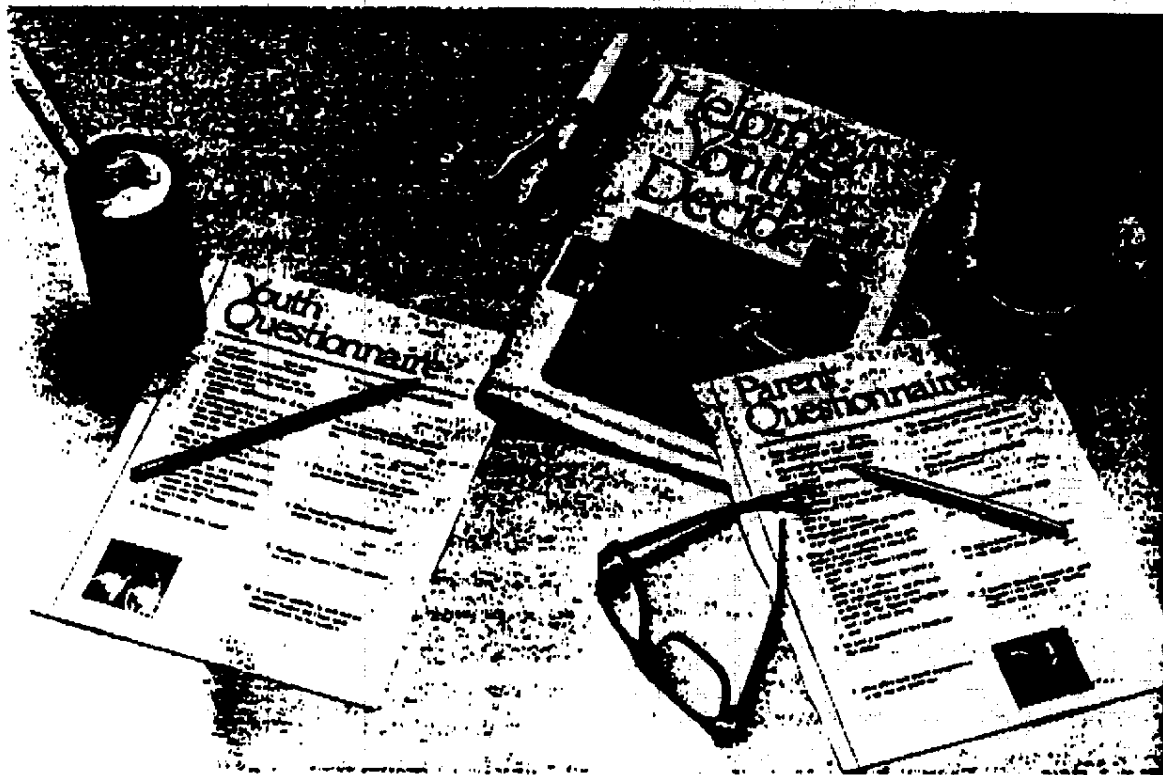
## Ready, Set, Go!

It has been said a journey of a thousand miles begins with a single step. And that first step is often the hardest. The questionnaires were your first step. You have taken a close look at how you are communicating *now*. And you have given some thought to how you want your communications to improve. The following exercises—a sort of "home-work" for parent and child—will help you to continue the journey toward improving your relationship.

## Option 1: Structured Discussions

Good communication begins with looking each other in the eye and saying what is on your minds. Perhaps you and your youngster have no trouble with that. But you may have found it hard staying on the subject. Your discussions sometimes ramble, which can lead to confusion and frustration.

If so, try using the questions below for structured discussions, keeping some special



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"rules" in mind:

1. Be direct and honest. Try not to dwell on past mistakes. Be respectful of each other.
2. Listen. If the parent is talking, the young person should be trying to follow the parent's argument and weighing the points made, and vice versa. This exercise may seem to encourage talking. But actually it requires *listening*.



3. Try not to interrupt. Don't think of your next comments while the other is talking. Ask questions of one another to clarify the points made. Work with each other to get to the bottom of each situation you've chosen.

Now read through these questions and together select three for discussion. Spend just five minutes talking about each. Confine yourself to answering these questions. If you have followed the "rules" you shouldn't stray from the subject.

1. What is the most important thing in the life of each of us now?
2. What is one of the dreams of each of us for 10 years from now?
3. When we were last upset with each other, how did we resolve our differences? Would we like to do it the same way the next time we disagree? If not, what would we like to change?
4. When we do things as a family—visit grandparents, worship, go on vacations—how do we make the decisions about when to go, where to go, who is going?

5. How do we make decisions about things like clothing and hair styles, smoking and drinking—individually or together? Whose opinions are important?
6. How can we assure the personal privacy each family member needs?
7. Do we fairly frequently give each other the benefit of the doubt? Can we think of an example when one of us did not and how the situation might have been improved?

## Option 2: Role Reversal

Perhaps you have no trouble looking each other in the eye. And you have no trouble sticking to the subject. But, still, you can't seem to resolve your problems.

This option works well for some. It is called "role reversal" because the parent takes the part of the adolescent and vice versa. This exercise helps both to empathize and to listen more effectively to one another.

Below are the beginnings of several stories. Each sets the stage for you to finish acting out the situation.

Remember: You are to play the part of the child. Your teenager is to play the part of the parent. Play your parts not as a comedy but as a drama. Stick to the same basic guidelines described in Option 1:



1. Be direct and honest.
2. Do not dwell on past mistakes.
3. Be respectful of each other.

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**The first story:** As soon as Bob gets home, after a difficult day at work, his 14-year-old daughter Susan asks if she can spend the weekend with her best friend, Judy, at the beach. . . .

**The second story:** Janet notices that her dresser drawer is open and that someone has apparently been reading her diary. Later, Janet's mother mentions something she could have learned only from reading the diary. . . .

**The third story:** Tom has been told to stop spending time with his friend Jack. Jack was recently suspended from school for fighting, the first time he ever had been in trouble. This weekend, Tom had planned to attend a concert with Jack. He still wants to. . . .

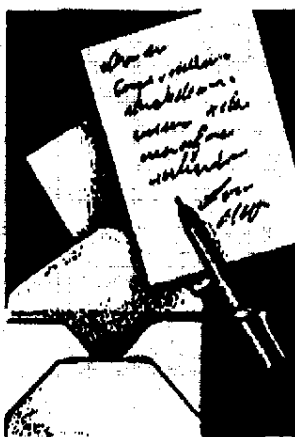
**The fourth story:** Jim's mother works and is not at home during the day. Jim called her at work, but she said she was unable to talk at the moment, and then forgot to call him back. When she gets home, Jim doesn't want to talk about it. . . .

---

## Option 3: Letters

Some people understandably have difficulty expressing themselves face to face. It's not always easy to look someone straight in the eye and say what you really think—that you love him, for example, or that you wish she would leave you alone, or that you are sorry about something you said.

Try writing letters to each other. Write as if you haven't seen each other for several months. Make the letters as long as you wish. This approach can help you learn to express your feelings to one another.



If it helps, you could (1) write as if you are talking about someone else, or (2) pretend you are writing to a best friend.

If you have a hard time getting started, go back to the questionnaire and select a ques-

tion that you marked "+" or "-". A "0" would be too complex to start with.

In any case, follow the rules that we have used before:

1. Be honest and direct. Don't beat around the bush or you're likely to cause confusion.
2. Don't dredge up a lot of ancient history. You may need to point to past problems. But don't dwell on them. No one likes to be reminded of mistakes.
3. Be respectful. Both of you are people. The biggest difference is that one of you is older.

# Practice Makes Perfect!

Adolescence is a time of growth and development, a time to sort out and begin to deal with the complexities of adult life. Young people must adjust to radical changes in their bodies, outgrow childhood emotions and begin to take on adult responsibilities. Moreover, it is a time when most young people make decisions about the direction their lives will take; when they examine for the first time the religious, ethical and political values of their families and society; when they choose vocational goals and undertake the education and training necessary to achieve these goals.

The ability to make choices rationally and responsibly is neither inborn nor easily acquired. Young people need help and practice in learning to make the decisions that affect their lives. We hope that this booklet has provided you with some guidelines for helping your young teenager lay the groundwork for responsible adulthood.



# Youth Questionnaire

1. I spend about \_\_\_\_\_ hours a week talking with my (mother) (father).
2. When something is bothering me, my (mother) (father) usually: (check the one that comes closest)
  - a. assumes my problems can't be all that serious.
  - b. figures it out before I say anything.
  - c. is willing to take the time to listen.
  - d. goes overboard and lectures me. I know (he) (she) means well but it never helps.
3. When I ask for permission to do something, my (mother) (father):
  - a. usually says "yes" because (he) (she) trusts me.
  - b. usually says "yes" but I wonder if (he) (she) is even listening.
  - c. questions me and sometimes really invades my privacy.
  - d. usually says "no" because (he) (she) doesn't trust me.
  - e. other \_\_\_\_\_
4. My best friends are: (list names)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. My most frustrating experience of the past few weeks was:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
6. My most frustrating experience with my (mother) (father) in the past few weeks was:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
7. One of the things about me that makes my (mother) (father) feel proud is:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
8. One thing that bothers my (mother) (father) about me is:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
9. The biggest decision I have ever made on my own is:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
10. A mutually agreeable decision that my (mother) (father) and I have made together within the last month is:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



51604 5802

# Parent Questionnaire

1. Right now, I spend \_\_\_\_\_ hours a week talking with my (son) (daughter).
2. When something is bothering (him) (her) I usually: (check the one that comes closest)
  - a. assume that the problem can't be all that serious.
  - b. am sensitive to the fact that there is a problem—and I am often right about what it is.
  - c. take the time to listen.
  - d. become deeply involved—giving freely of my experience and advice.
3. When my (son) (daughter) asks for permission to do something, I: (check the one that comes closest)
  - a. usually say "yes" because I trust (him) (her).
  - b. usually say "yes" because (he) (she) is going to do it anyway.
  - c. want more information and may want to check things out for myself.
  - d. usually say "no" because (he) (she) has such a poor track record.
  - e. other \_\_\_\_\_
4. My (son's) (daughter's) best friends are: (list names)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. (His) (Her) most frustrating experience in the past few weeks was:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
6. The most frustrating experience (he) (she) had with me in the past few weeks was:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
7. One thing about my (son) (daughter) that I am proud of is:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
8. One thing that bothers me about (him) (her) is:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
9. The biggest decision my (son) (daughter) has ever made on (his) (her) own is:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
10. A mutually agreeable decision my (son) (daughter) and I have made together within the last month is:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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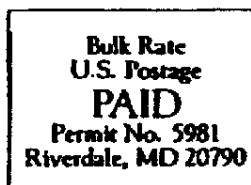


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# Questionnaires

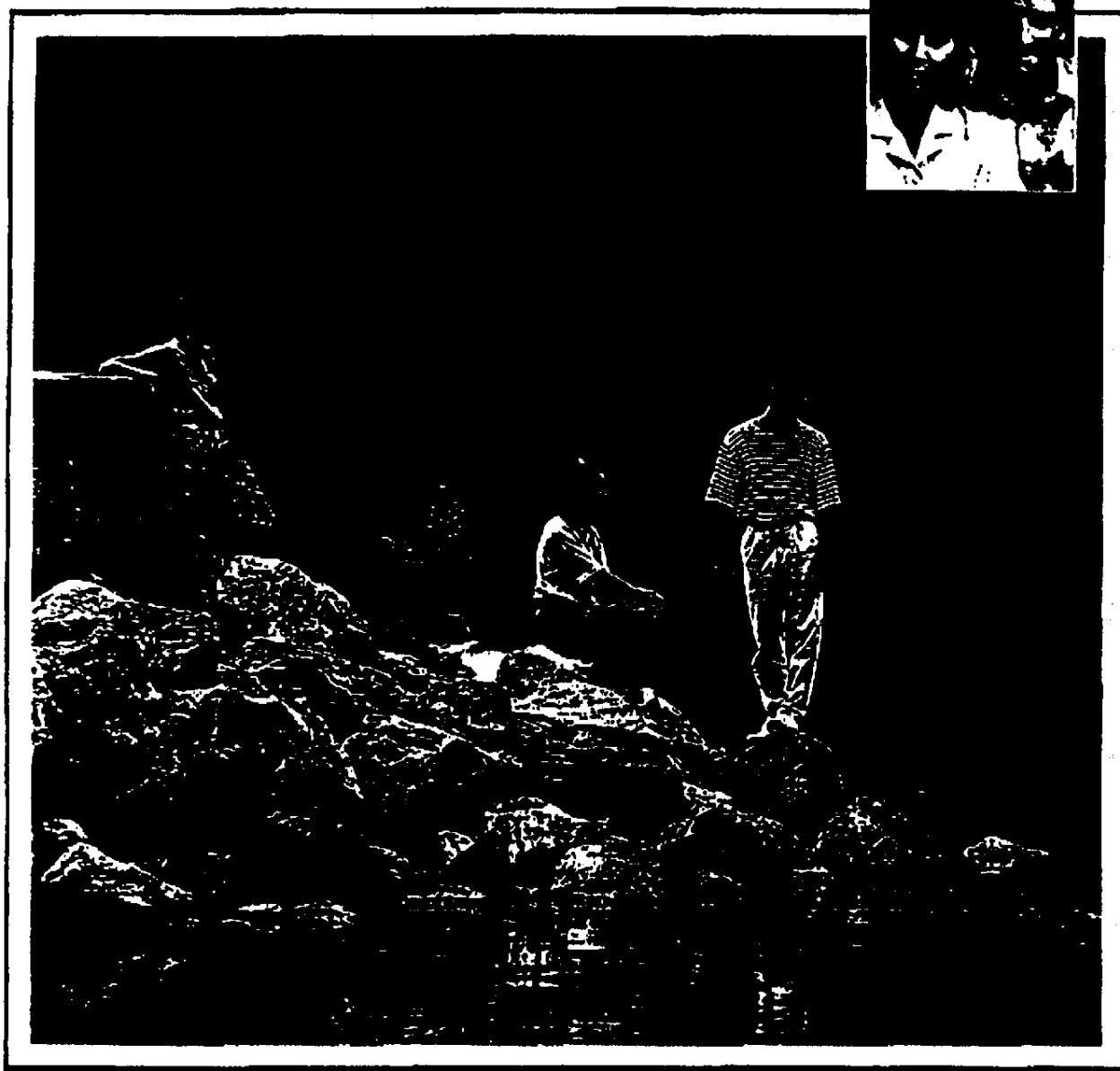
National Association of State Boards of Education  
P.O. Box 1176  
Alexandria, VA 22313

51604 5805



# Tobacco: Helping Youth Say No

A Parent's Guide to  
Helping Teenagers Cope With  
Peer Pressure



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*The Tobacco Institute wishes to thank the following individuals for their guidance in producing this publication.*

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# Introduction

**R**aising a family is one of life's greatest challenges—and one of its greatest rewards. But today, it may be more difficult than ever because family structures are different. There has been a dramatic increase in single-parent families, new families created by remarriage and families with both parents who work outside the home.

As a result, many parents have less time to spend with their children. Young people are on their own more often than in the past and are trusted with greater responsibilities. So establishing open lines of communication early on is critical. If your children can talk to you, no matter how personal the subject, then you can help guide them in making good decisions.

In addition to your influence, another major factor affecting the decision-making process is the presence of peer pressure. Peer pressure can affect anyone, no matter what the age. But it is an especially powerful influence on children, who do not have the maturity or experience to make responsible decisions on their own—including those decisions that may be criticized by their friends. Peer pressure also has an impact on children at a far earlier age than ever before. Building strong family relationships will help your children handle peer pressure and make responsible decisions.

Not smoking is one such responsible decision for children. More than likely, your children will be tempted by their friends to smoke. And although they receive lots of information to the contrary from their teachers, coaches, doctors, clergy, community organizations and television, these sources do not and should not replace the influence you have as a parent. This is why you, as the person they depend upon the most, should use this information as a guide to help you help your children refrain from smoking.

"Tobacco: Helping Youth Say No" is the third in a series of booklets designed to increase communication between parents and children and to raise levels of mutual respect and trust. In the following pages, you will find some suggestions for talking with your children to discourage tobacco use. Part 1 of this booklet discusses the role of peer pressure and its effect on children as they learn how to make responsible decisions. Part 2 is aimed at helping you as parents prepare for a discussion on one decision-making challenge your children may face: saying no to tobacco. Part 3 offers practical exercises that will help open the lines of communication between you and your children.

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# Part 1 Growing Up

**W**henever we struggle through a particularly rough period in our adult lives, it's rather tempting to wonder, "Wouldn't it be nice to be 16 again, or even 12?" And why not? Adolescents seem to have it fairly easy — school, friends, parties, sports, video games, movies — despite some homework, chores and maybe a part-time job or "unwelcome" music lessons after school.

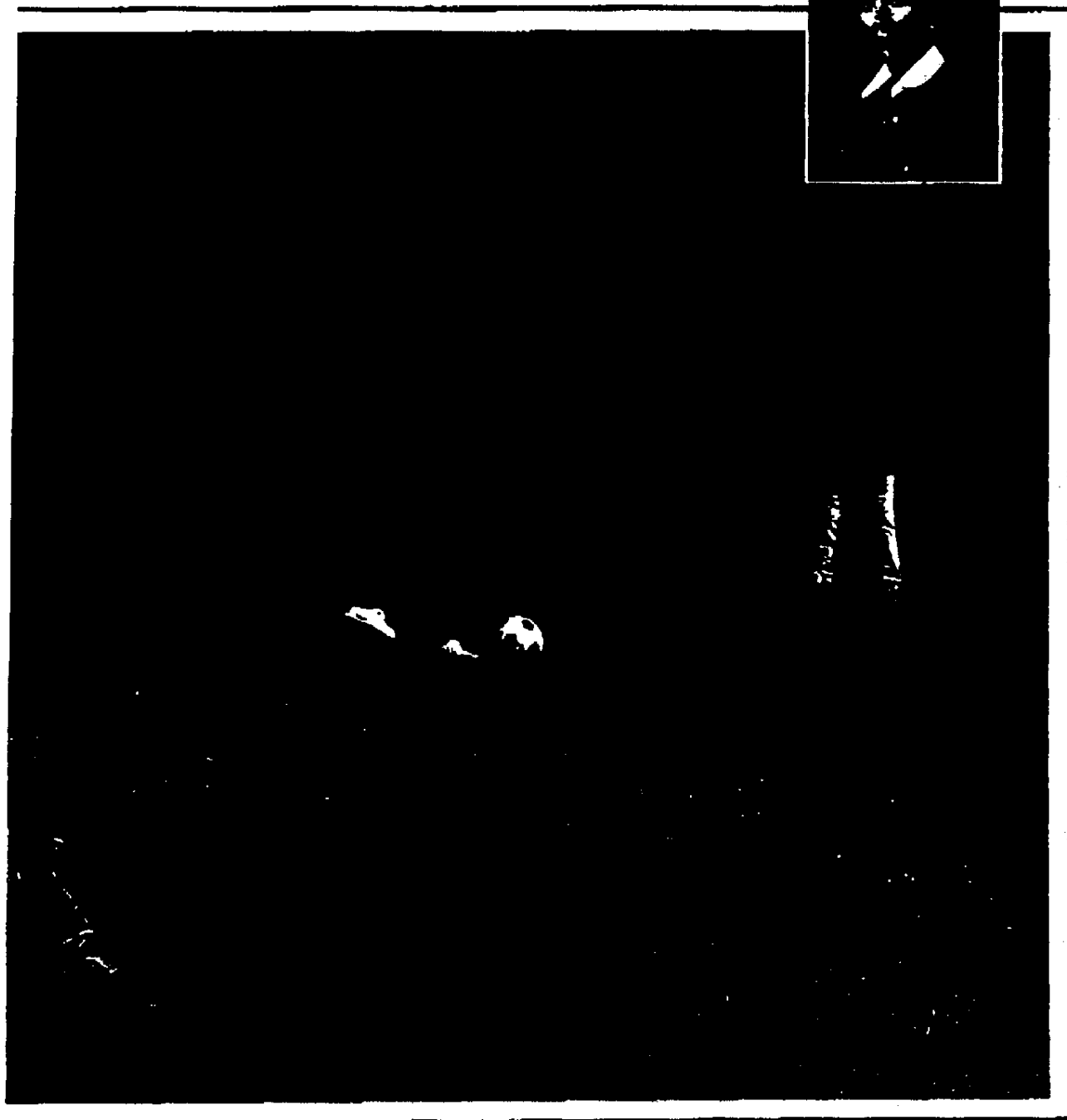
But growing up is not always easy. Teenagers, especially, may have a rough time as they struggle to become adults.

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The pressure upon children to fit in, to succeed academically, socially or in sports, is enormous. Something as simple as wearing the "wrong" clothes can be a traumatic experience.

Growing up today is also different from the way it was just 10 or 20 years ago because society

has changed. Children are involved in adult activities at a far earlier age than ever before. For example, sexual activity and pregnancy rates among teens and pre-teens have escalated.



51604 5810

## The Role of Peer Pressure

Is peer pressure the reason children are experimenting with adult activities? Often. Most people, and especially children, want to belong to a group, to be accepted by those around them. Some peer pressure can be good: the competition to get good grades or to make the football team or to get a part in the school play. But it can also be bad.

Peer pressure has an enormous influence over your children, and the temptation to experiment and to be one of the group sometimes becomes too strong to resist. It's when peer pressure encourages negative behavior that parents should become concerned.

As parents, you do your best to teach your children the difference between right and wrong. But it's a tough job made tougher when you find yourself in the frustrating situation of having to say, "Do as I say, not as I do."

The fact is, by definition children cannot, and should not, do many of the things adults choose to do. Most parents work hard to be a positive role model for their youngsters. All you can do is your best. But, for example, whether or not you choose to drink or smoke, it is still your responsibility to discourage your children from drinking and smoking, until they are mature enough to make those adult decisions.

Other members of the family also influence children. Pre-teens frequently want to imitate their teenage brothers or sisters. We've all heard, "If Jett's doing it, why can't I?" Children like to act older than they are.

Society also plays a role, sometimes forcing young people to grow up before they should. In single-parent families, for example, the oldest child may take on the role of a parent. As a result, this child may feel that he or she has also "earned" the right to take part in adult activities.



A child's natural development is part of the equation, too. Younger children usually accept their parents' beliefs. But as they grow older, they often find themselves questioning those same beliefs. In their desire to be independent, they try to balance their parents' teachings with their friends' opinions and their own beliefs. They are searching for their own identity as well as their independence, which is fine. You want them to become self-reliant. But they still need guidance, patience and understanding.

Although adolescent rebellion is common, it is also true that, as parents, you have more influence on your children's behavior than you may feel at times. The amount of your influence can be increased by the trust, support and understanding you have within your family. By communicating and being involved and interested in your youngsters' activities, you help to build their self-confidence—the strongest antidote for peer pressure.

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## Strong Parents = Strong Children

Communication between parents and their children is vital to creating a loving and trusting relationship. As a parent you need to listen, empathize and be involved. As your child grows, so will outside influences. But your guidance will remain the most important influence of all in helping your children to become self-sufficient and responsible.

Showing an interest in your children's activities and helping them set realistic goals are part of the process of preparing them for adulthood. When your child announces an intention to try out for the track team, you can help by discussing the time and dedication needed for training and competition—and also the rewards. If your child wins a spot on the team, show your support by attending the track meets whenever possible. Regardless of how well your child does, your love and encouragement will help him or her stick

with the decision and, in turn, boost your child's self-confidence.

However, a loving relationship can be threatened if a parent is too critical. Instead of attacking your child, attack the problem at hand. If your son is caught skipping school, don't simply shout or resort to name calling. Try to find the reason for his actions—perhaps he's having trouble with classes or his friends dared him to do it. Find out what the real problem is so you can work toward solving it.

Another way to raise strong and independent children is to encourage responsibility and problem-solving at an early age. Even five- and six-year-olds can learn to pick up their toys, especially if they realize what the consequences are—no television or bedtime story—if they don't. The more practice children have making decisions during the early years, the greater their decision-making skills will be later in life.



51604 5812

## Steps to a Responsible Decision

Making good decisions isn't easy. Since you can't be with your children at all times, nor do they always want you around, you must lay the groundwork on which they can form their own values and make their own judgments. They need your guidance in learning the decision-making process.

One way to help your children learn good decision-making skills is to let them express their own ideas and feelings at a very young age. It's



important for them to know you're interested in what they think. In addition, you may want to use the following steps the next time you talk about a tough decision with your child:

1. *Discuss the problem.* What is it you need to do or decide? What do you know about this issue?
2. *Gather more information.* What do you know from other experiences that would help? What do you need to know more about before making the decision?
3. *List the alternatives.* What are all the possible choices? Are there others you've forgotten?
4. *Examine the consequences.* What will be the results, good and bad, of each alternative? What are the consequences, in the short and long run, of each? How do you feel about each choice today? How do you think you will feel next week? Next year?
5. *Consider feelings and values.* How do you feel about each alternative? Each consequence? How does each fit with your values, your family's values and community expectations?
6. *Choose the best possible course of action.*

Try going through the steps together. Your children need to know that what they have to say is important to you. Encourage them to ask questions.

Of course, the ability to make sound decisions does not happen overnight. We all have difficulty making the right choice, at times. But helping your children consider the consequences of each alternative may reduce some of the confusion. This will enable them to see each situation clearly enough to make the best decision possible.

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# Part 2A Responsible Decision About Youth Smoking--- Don't

**L**ife is full of activities in which young people should not take part. Smoking is one of them. Smoking is not a choice for children because they do not have the maturity needed to make judgments that weigh all considerations. But explaining that to your children can be difficult.

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Talk to your children about smoking *before* they consider it. Simply telling your children not to smoke because "I said so" is unlikely to deter them. In fact, it might do just the opposite. What child is not tempted to try what is forbidden?

Your children should be involved in the decision not to smoke. That's why it's important to start the education process early. As most parents know, children are naturally curious and tend to ask lots of questions. Some of these questions come up because of something that happens at

school. Many schools now have anti-smoking educational programs, even at the elementary level. So it's quite possible your child will follow up a class discussion about smoking with questions at home.

Your children's questions about cigarettes are a natural starting point for a frank discussion about smoking. And even if your children don't raise the subject themselves, experts agree: Parents should.

51604 5815

## Children Shouldn't Smoke

Research on youth smoking tells us that children are heavily influenced by parents, friends and family members. Peer pressure, in fact, is the single most important motivating factor outside the family.

Children often choose to smoke with friends as a way of fitting in. Even teenagers with good judgment would sometimes rather defy Mom and Dad than reject their friends' pressure to smoke. But smart youngsters who have discussed this issue with their parents ahead of time know smoking isn't the way to fit in.

What do you say about tobacco use? When you discuss why your children should not smoke, it will be helpful to discuss how hard it may be to not do what their friends may be doing. Let your children know that you realize it's tough not to go along with the crowd. But remind them that it can be "cool" to set the trend instead of just doing what others are doing.

Young people are aware of the claims that smoking presents risks to one's health. As the Surgeon General has stated, "By the time they reach seventh grade, the vast majority of children believe smoking is dangerous to one's health." However, young people are not experienced enough to use the information available to formulate their own decisions. That's why decisions regarding smoking and other adult activities, such as drinking and sexual activity, should be made as an adult.

Your children also should know it's illegal to sell tobacco products to minors — and in some places illegal for minors to buy tobacco products — even though tobacco products are legal for adults. Almost every state and even some localities have set age limits for the sale of tobacco products. Know the laws in your state. Although the minimum age laws differ slightly, most states have declared it unlawful for retailers to sell cigarettes or other tobacco products to anyone under the age of 18.



Not only do penalties exist for the retailer who sells tobacco products to minors, but in some states, the young person caught buying cigarettes is also punished by fines and/or community service. Remind your children that they could land themselves in trouble or get someone else in trouble if they try to buy tobacco products.

The following sample conversation may be helpful in explaining why your children shouldn't smoke.

**Daughter (age 10):** We had a special teacher come to class today to talk about smoking. She told us that we shouldn't smoke and that smoking is bad for you. But I see people smoking all the time, Dad. Why do they do it?

**Father:** Your teacher is right when she says you shouldn't smoke. Some adults may choose to smoke but there are many activities in which young people shouldn't participate. Your friends may be smoking because they think it's cool for kids to smoke, but it's not. Children shouldn't

smoke. That's why it's against the law to sell you cigarettes — you're not old enough to buy them.

**Son (age 16):** C'mon, Dad, give me a break! Lots of kids smoke at school. It's no big deal. Besides, I'm 16 and can drive a car. So why can't I smoke if I want to?

**Father:** It is a big deal. Just because other kids smoke at school doesn't mean you have to. Hey, if other kids asked you to cheat on an exam, would you do it? We both know you're smarter than that.

**Son:** Yeah, I'm smart, but I'll look like a nerd if I don't smoke cigarettes with them.

**Father:** I know it's not easy being teased at school, but you don't have to follow their lead. Most kids don't smoke. Why don't you be the leader and encourage your friends not to smoke?



## Helping Youth Say No

Encourage your children to discuss their reasons for smoking, or why they are thinking about it. This will better enable you to respond to their needs and concerns. In your discussions, try to avoid correcting, criticizing or commanding. A warm and trusting environment fosters an open dialogue for examining the complex issues surrounding tobacco use.

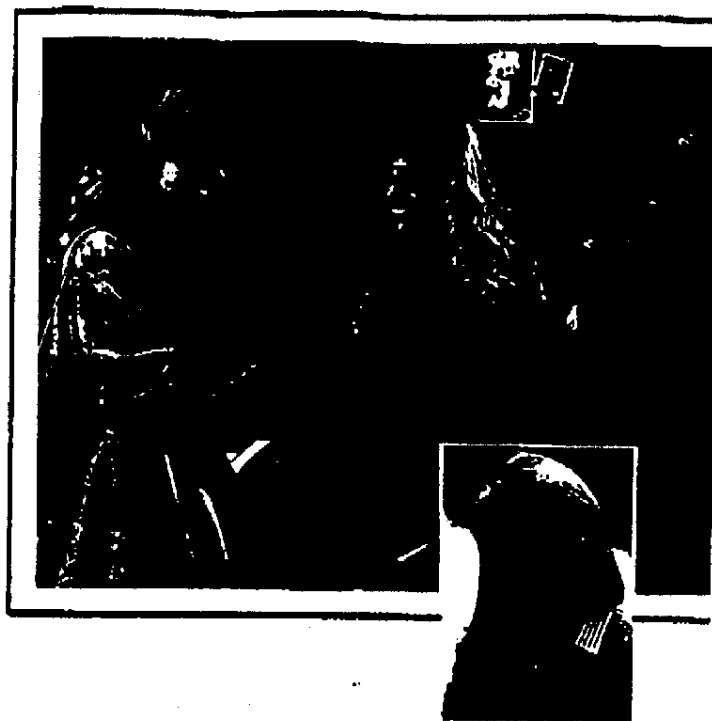
As parents, you need to help your children practice saying no to smoking, and to other inappropriate activities. Although young people are more likely to express their individuality if there's little risk of embarrassment, they need to understand the importance of standing up to the rest of the crowd.

Naturally, no matter what their age, children often rebel against the thought of too much parental control. But once they realize how much they are being affected by peer pressure, they may not like the idea of being controlled by their friends, either.

How to say no is an important lesson for your children. It's not always easy for children to say no on their own, so why not tell your children to use you as an excuse? For example, "A cigarette? No thanks, my parents would ground me for a month if they caught me smoking."

Or suggest using humor to help ease a tense situation. "I wouldn't see the car keys till I'm 35! Smoking's not worth that!"

It's also a good idea to advise your children to be prepared for problems that may arise. Encourage them to picture in their minds a situ-



ation they may face during or after school. Then ask them to picture how they would deal with that situation. This will better equip your children to deal with difficult situations.

You can also help your children say no to smoking by sharing experiences. You may have a story from your childhood that's appropriate. Perhaps you were once faced with being laughed at if you didn't smoke with the rest of the crowd. Your child can benefit from the knowledge that he or she isn't the only one who has had to face this type of situation.

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## When You Have To Say No

After you have talked about why children shouldn't smoke, a pre-teen child is more likely to accept your decision on smoking as their own. However, teenagers may believe they are still capable of making their own choice, so sometimes you must step in and lay down some rules. Setting limits is part of being a parent.

Once you've made your viewpoint known on the issue, be firm, fair and especially consistent with the rules you set forth. Encourage your children to use your rules as an excuse not to go along with the rest of the crowd. It helps to lift some of the pressure off their shoulders.

Although they may not show it at the time, children are grateful for parental guidance when it helps them with a problem they're not sure how to solve. When parents use a firm, but caring tone, younger children are more willing to accept their parents' decisions, and older children recognize it as an expression of their parents' love and respect.

Working together, parents can help their children decide not to smoke.

If you would like additional information and guidance to help your children handle other difficult decisions, please write for your copies of "Helping Youth Decide" and "Helping Youth

Say No: A Parent's Guide to Helping Teenagers Cope With Peer Pressure."





# Part 3 Toward Better Communi- cation

**T**his booklet has set the stage for a frank discussion between you and your children about smoking. But before you begin talking about this tough topic, you need to make sure the lines of communication are wide open. You and your children can start by completing the questionnaires and conducting a "role reversal" exercise.

51604 5820

## Youth Questionnaire

Taking an inventory of your children's feelings about you, and their perceptions of your relationship, will help develop a better rapport. If the lines are already open, the following exercises may help you make that exchange even better.

The questionnaires in the back of this booklet should be separated and answered by each of you independently. For the best results, do not

discuss the questions or look at each other's answers until both of you are finished.

Once the questionnaires are completed, discuss each answer with your children. You will gain a better understanding of how effective the lines of communication are in your family, and where they can be improved. By knowing where the lines of communication are strong, you can build on these strengths. And by recognizing where there are weaknesses, you can work with your children to eliminate them.



## Changing Places

You've probably heard the expression about putting yourself "in someone else's shoes" to understand a certain situation. It might be helpful to assume the role of your child, while your child pretends to be the parent. This exercise, called "role reversal," helps build a better understanding of each other's feelings, and helps teach you and your child the art of effective listening.

The following are several stories that need to be finished. Each of you should take a turn to finish acting out the situation.

Remember: You are to play the part of the child. Your teenager is to play the part of the parent. Don't make light of this game; play it seriously for the best results. And follow these basic guidelines:

- 1) *Be direct and honest*
- 2) *Don't dwell on past mistakes*
- 3) *Be respectful of each other*



**Story # 1:** Monday is "skip day" — an unofficial holiday for students at Tom's high school. Tom is thinking about taking the day off — all of his friends are — but he knows that his parents would not approve, and, if they found out, would probably ground him. He calls his friend Steve and...

**Story # 2:** Susan has a good friend named Beth. One day, Beth pulls her aside in the locker room and tells Susan that she took some cigarettes from her older sister and that she wants to smoke them after school. Beth asks Susan to join her. After school, Susan meets Beth and tells Beth...

**Story # 3:** Martha is at a party with about 20 other friends. Everyone is having fun, dancing, talking, listening to music. Peter pulls out a pack of cigarettes and begins passing them out to people in the room. He turns to Martha to offer her one and she...

**Story # 4:** Dennis' parents were out of town one weekend. Dennis, who is 17, and his older brother, Greg, who is 22, decide to have some friends over to watch a basketball game on television. Greg's friends arrive with an ice chest full of beer. They begin offering the beer to Dennis and his high school friends and...

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# Youth Questionnaire

- 1) When I am upset about something, I usually:
- keep it to myself and don't tell anyone about how I am feeling.
  - tell my (mother) (father) about it.
  - tell my best friend about it.
- 2) I spend about \_\_\_\_\_ a week talking with my (mother) (father). I think we:
- should spend more time talking.
  - spend enough time talking.
- 3) When something is upsetting me, my (mother) (father) usually: (check the one that comes the closest)
- acts like my problems aren't all that serious.
  - stops whatever (she) (he) is doing to listen to me.
  - figures it out before I say anything.
  - starts lecturing me.
- 4) List your five closest friends in order of importance. Write the one word that describes why you like them next to their name, like: John — friendly.
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- 5) In the past few weeks, the one thing that bothered me the most was:
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- 6) In the past few weeks, the one thing that bothered me the most about my (mother) (father) was:
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- 7) Whenever my (mother) (father) says (she) (he) is proud of me, it is usually because I:
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- 8) When my (mother) (father) gets mad at me, it is usually because I:
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- 9) The biggest decision I have ever made on my own is:
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- 10) The toughest decision I ever made with the help of my parents was:
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

# Parent Questionnaire

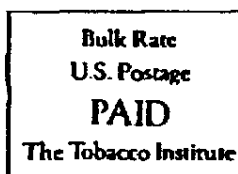
- 1) When my (son) (daughter) is upset about something, (he) (she) usually:
- does not share (his) (her) feelings with me.
  - tells me about it.
- 2) I spend about \_\_\_\_\_ a week talking with my (son) (daughter). I think we:
- should spend more time talking.
  - spend enough time talking.
- 3) When my (son) (daughter) is upset about something, I usually: (check the one that comes the closest)
- assume that the problem isn't all that serious.
  - take the time to listen.
  - recognize that there is a problem and I am often correct about what it is.
  - become deeply involved — giving freely of my experience and advice.
- 4) List your (son's) (daughter's) five closest friends in order of importance.
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- 5) In the past few weeks, the one thing that bothered my (son) (daughter) the most was:
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- 6) In the past few weeks, the one thing that bothered my (son) (daughter) about our relationship was:
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- 7) Whenever I say I am proud of my (son) (daughter), it is usually because (he) (she):
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- 8) When I get mad at (him) (her), it is usually because (he) (she):
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- 9) The biggest decision my (son) (daughter) has ever made on (his) (her) own was:
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- 10) The toughest decision (he) (she) ever made with my help was:
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

# Questionnaires

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The Tobacco Institute  
P.O. Box 41130  
Washington, DC 20018

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R. J. REYNOLDS'

YOUTH NON-SMOKING PROGRAM

BACKGROUND

Incidence of underage smoking has remained largely unchanged over the last ten years with approximately 19% of high school seniors claiming to smoke on a regular basis. Youth non-smoking intervention methods during this time have consistently focused on providing health messages -- despite near universal awareness of smoking and health issues. It is clear that alternative intervention techniques must be explored in order to further reduce underage initiation.

R. J. Reynolds has decided to take the lead in exploring new methods of discouraging smoking among youth. The Company's rationale for aggressively searching for a solution to underage smoking is two-fold:

- Simply stated, kids shouldn't smoke. It has always been the industry's position that smoking is an adult custom. Moreover, studies have identified smoking as a risk factor for certain diseases, such as lung cancer, heart disease and emphysema. While there are many other factors associated with a person's chances of developing specific diseases (e.g., diet, stress, occupation, etc.), the decision to smoke, like many other personal lifestyle choices, should only be made by informed adults.
- The emotionalism surrounding the youth smoking issue has often resulted in restrictions that unfairly discriminate against adult smokers. Regulators frequently hold the industry responsible for underage smoking despite minimum-age laws and convincing evidence that peer pressure and parental guidance are the key factors in initiation. It is assumed, therefore, that reductions in underage smoking will be accompanied by reduced support for unfair restrictions being imposed on adult smokers.

In developing the youth non-smoking program, R. J. Reynolds conducted extensive primary and secondary research to understand the adolescent target and expert opinion on intervention techniques. In essence, Reynolds has utilized a consumer marketing approach to maximize the relevance and appeal of the youth non-smoking communication and delivery vehicles. This unique approach is demonstration of Reynolds' desire to be part of the solution to underage smoking. Reducing the incidence of underage smoking will be a difficult task and success will not come quickly.

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The following details the strategic rationale and research findings on R. J. Reynolds' youth non-smoking initiative.

#### PROGRAM OBJECTIVE

R. J. Reynolds' youth non-smoking program has two primary objectives:

- Discourage smoking initiation among adolescent youth.
- Show industry/RJR support for youth smoking efforts as means to minimize additional action against adult consumers.

#### PROGRAM STRATEGIES

1. Develop and introduce impactful and relevant youth non-smoking messages focusing on the key factors in smoking initiation -- peer pressure and parental guidance.

Research has consistently demonstrated that adolescent youth are well aware of the issues surrounding smoking and health. There is even evidence to suggest that teenagers consider smoking to be potentially more harmful than experimentation with "hard drugs." Despite this belief and continued saturation of health-related messages, underage smoking incidence has remained unchanged for the last 10 years.

The ineffectiveness of the existing youth non-smoking effort is due to the longer-term nature of smoking and health messages being in sharp contrast with the short-term nature of the adolescent mind. This inconsistency and relative ineffectiveness of health based messages is even acknowledged by the anti-smoking forces:

- Julia Carol, Assistant Director of American's for Non-Smokers Rights, recently wrote that "the health consequences of smoking, surprisingly, is the least effective part of any [youth directed] prevention program." Child development experts agree that peer pressure and role model influencers play the largest role in initiation. Moreover, public opinion surveys indicate that peer pressure and parental guidance are seen as the most effective ways to discourage underage smoking.
2. Tightly target communication directly against adolescents most at risk for underage experimentation -- middle school aged youth (12-15).

Studies indicate that by the time an adolescent reaches high school, several lifestyle behaviors have already been adopted -- including the decision whether or not to smoke. In fact, a recent study funded by the Centers for Disease Control suggested that school systems emphasize smoking intervention programs before senior high school. The study had found that most school systems tended to emphasize a non-smoking curriculum in the tenth grade.

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3. Employ unconventional methods of delivering the youth non-smoking message to demonstrate R. J. Reynolds' commitment to reaching the target audience.

R. J. Reynolds' youth program is intentionally designed to impact the hard-to-reach adolescent age group via creative and unique delivery vehicles -- e.g., near school OOH, school bus programs, in-school programs, etc. This approach will credibly demonstrate that R. J. Reynolds' youth program is substantially more than a token effort and represents a sincere attempt to be a part of the solution.

- Critics have often charged the tobacco industry with employing sophisticated and creative marketing techniques to target specific adult consumer groups. Unique targeting techniques employed in the youth non-smoking program can have the ancillary benefit of helping defuse the allegations of "irresponsible and predatory" marketing to adult consumer groups.

#### RESEARCH SUMMARY

The following highlights learning obtained from several rounds of qualitative research conducted among middle-school aged youth and parents. In all, over 150 adolescents and 50 parents were interviewed during the development process.

- Peer pressure is universally seen as the single most important factor in underage smoking by both parents and youth. Most adolescent respondents indicated they felt peer pressure to experiment with cigarettes, alcohol and drugs by the age of 12 or 13. R. J. Reynolds' campaign was seen as a potentially effective way to moderate peer pressure by reinforcing self-esteem and communicating that "it's ok to be yourself and express yourself...you don't need to smoke to fit in."
- Adolescents positive attitudes toward the campaign were due to situational relevance and "non-preaching" tonality of the message. Youth respondents indicated that the Bathroom execution placed smoking in its proper perspective (sneaky and not cool) and was a situation they see nearly every day. Similarly, the Smokescreen execution reinforced the fact that most of their friends do not smoke and you don't need to smoke to have a good time. Importantly, all the executions tend to communicate a positive reason not to smoke rather than merely preaching the negatives.
- Adolescents value established friendships and pride themselves in exercising a great deal of tolerance toward the behavior of others. Executions interpreted as suggesting that underage smokers are stupid, anti-social or inferior are rejected since many have friends who smoke. Respondents clearly preferred those executions that promoted friendship (Express Yourself) or only hinted at peer rejection (Smokescreen).

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- Many respondents (youth and parents) felt that the R. J. Reynolds campaign was both more relevant than the current California anti-smoking effort and potentially more effective. Interestingly, youth and parents differed in their rationale for this belief. The adolescent tends to see the R. J. Reynolds effort as "speaking directly to me" whereas adults saw the campaign's social message as more motivating than a health-based message. As noted earlier, this latter view is consistent with that of developmental psychologists and is reflected in the low perceived effectiveness ratings of the California campaign -- only 33% of California adults feel that the Prop 99 advertising is an effective way to discourage youth smoking.
- Parents were surprised to learn that the youth directed ads were produced by R. J. Reynolds. Adult respondents initially assumed that the ads were developed by the American Cancer Society or other non-profit organization. The vast majority of adults (smokers and non-smokers) saw the campaign as a big step in the right direction resulting from obvious pressures on the tobacco industry. Regardless of R. J. Reynolds' motives for developing the campaign (many saw it as a way to reduce external pressures), parents considered youth as the beneficiary of the effort.
- The adult directed ads effectively reinforced top-of-mind awareness that parental guidance is a key factor in smoking initiation. At a minimum, parents felt that the ads serve as a reminder to keep the lines of communication open. Smokers were particularly interested in How To Talk To Your Kids About Not Smoking Even If You Do since most have difficulty reconciling a non-smoking message with their own behavior. Both smoking and non-smoking parents considered the booklet to be very helpful, credible and to the point. Respondents were pleasantly surprised that the booklet was hard hitting and void of "sugar coating."

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## R. J. REYNOLDS YOUTH NON-SMOKING EFFORTS

### I. HOW WAS RJR YOUTH NON-SMOKING PROGRAM DEVELOPED?

- A. Program development began in 1990 as extension to Tobacco Institute efforts announced in December, 1990.
  - 1. Tobacco Institute programs touched on retail access and parental involvement.
  - 2. RJR saw opportunity to expand scope and delivery of youth non-smoking messages developed by TI.
- B. First step was an exhaustive review of existing research regarding Antecedents of Adolescent Smoking.
  - 1. Analyzed U.S. and worldwide studies.
  - 2. Analyzed studies/articles/literature produced by objective researchers (child/adolescent psychologists and behavioralists, etc.)
  - 3. Analyzed public record/statements of anti-smoking advocates.
- C. Analyzed available information on adolescent prevention/intervention programs and effectiveness studies.
  - 1. Assessed types of programs that seemed to be working the best.
  - 2. Determined what programs are currently being used in schools/parents.
- D. Identified a "niche" that RJR could fill that was not adequately being addressed by existing programs.
  - 1. Youth Directed.
  - 2. Parent Directed.
  - 3. Retail Directed.
- E. Developed concepts and programs for each target group utilizing secondary research sources.
- F. Researched concepts/programs with youth, parents and child experts.

### II. ANTECEDENTS OF ADOLESCENT SMOKING

- A. Enormous body of empirical evidence indicating that peer influence, parental guidance and accessibility are the primary correlates to youth smoking.

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1. Peer influence and family influence supported by cross-sectional studies, longitudinal studies and retrospective studies.
  2. Limited quantity of quality accessibility - related studies. However, studies by and large indicate that a) compliance with minimum age laws is weak, and b) stricter support/enforcement of existing laws is needed to enhance compliance.
- B. Advertising's effect (if any) on youth smoking rates is generally not addressed in most large, objective social influence models. The limited public record citing advertising as a key influencer is limited to articles authored by anti-smoking groups.

### III. ADOLESCENT PREVENTION/INTERVENTION PROGRAMS

- A. Review of published studies/literature indicates that prevention/intervention programs can be classified as follows:

#### 1. Traditional Approaches

- a. Informational Models: Stresses health effects of smoking and assumes information/knowledge of health consequences will alter behavior. This is the dominant form of intervention in schools and universally acknowledged have limited effectiveness.
- b. Affective Models: Programs designed to enhance self-esteem/image, decision-making abilities and goal setting. Largely ineffective when exclusively relied upon as intervention technique.

#### 2. Psychosocial Approaches/Social Psychological Theories

- a. Social Influences Models: Recognizes adolescent smoking as primarily a social behavior. Programs include (1) information on negative social effects of smoking; (2) effects of social influences including peers, parents and media; (3) correcting inflated perception of prevalence; (4) refusal training techniques. Overriding consensus is that social influence approaches can be the most successful.
  - b. Cognitive Behavioral Models: Similar to social influences but stresses role-playing, rehearsal and decision-making.
  - c. Life Skills Models: Combines Social Influences Model, Cognitive Behavioral Model and Affective Programs into one. Generally seen as effective.
- B. A review of existing priorities nationally indicates (a) schools tend to focus on Informational Models which have limited effectiveness; and (b) literature suggests that late elementary/early middle school is optimal age to train students yet primary focus currently tends to be in high school.

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C. Availability of quality, retail-based research is limited. Research does suggest that awareness/education of local age laws can make a short-term difference. Strict enforcement, however, is seen as holding most promise for compliance-based programs.

1. Retailer education must be consistent and frequent.
2. Education must target sales clerk.
3. Likelihood of strict enforcement (as defined by anti-smoker models) is doubtful given other law enforcement priorities and limited resources.

#### IV. RJR YOUTH NON-SMOKING PROGRAMS 'FILL A VOID' IN EXISTING INTERVENTION/PREVENTION PROGRAMS

##### A. "Right Decisions, Right Now" Programs

##### 1. Youth-Direct Materials

- a. Advertising Communication Programs: Programs featuring relevant youth non-smoking advertising addressing social reasons for initiation (peers), stimulating consideration of rejection techniques and enhancing self-esteem. Programs include in-school posters and tent cards, book covers provided to school systems, and outdoor advertising located at near-school locations.
- b. Teachers Study Guides: Training materials helping teachers help students make appropriate lifestyle decisions through role-play, study guides and discussion posters. Reaches two million junior/middle high students twice per year.
- c. Youth Brochure: Youth-directed brochure designed to encourage adolescents to make appropriate lifestyle decisions. Reaches one million middle/junior high school students twice per year.

##### 2. Parent-Directed Materials

- a. "How To Talk To Your Kids About Not Smoking Even If You Do" Booklet: Booklet designed to help smoking parents discourage their children from smoking. Addresses unique needs of smoking parents. Offered via outdoor advertising, print advertising and distributed in some school districts and retail outlets.
- b. Parent-Directed Advertising: Advertising campaigns designed to a) heighten awareness among parents of their responsibility in discouraging youth smoking (e.g., Kids Shouldn't Smoke. Talk To Yours Today) and b) educate parents to the availability of materials from RJR. Programs are executed via OOH and ROP/magazine advertising. The Tobacco Institute booklet "Tobacco: Helping Youth Say No" is also distributed through these channels.

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B. "Support The Law - It Works!" Retail Program

1. Retail Training Program: Comprehensive program to help retailers/store clerks comply with minimum age laws. Components include in-store signage, training video program, informational brochures and employee oriented POS signage. Retailers enlisted in program through trade advertising, trade association publications and RJR Sales/Public Issues personnel.
2. Trade Advertising: Advertising in major trade association publications informing retailers of the importance of complying with minimum age laws and offering an 800 number to sign up for free materials.
3. "It's The Law" POS Signage: RJR allocates space on selected merchandisers to display TI's "It's The Law" message informing patrons of the state's minimum age law regarding tobacco products.

V. PRIMARY RESEARCH CONDUCTED BY RJR INDICATES THAT PROGRAM MATERIALS A): COMMUNICATE RELEVANT NON-SMOKING MESSAGES TO YOUTH; B) ARE HELPFUL TO PARENTS; AND C) PROVIDE A VALUABLE SERVICE TO RETAILERS.

A. Youth-Directed Primary Research

1. Campaign communication among adolescent youth.
  - a. Extensive qualitative research (focus groups) and limited quantitative research (communications testing) conducted among males and females, 12- to 15-years-old across the country. Utilized screening mechanism to identify "at risk" youth (e.g., peer group, organized activities, grades, etc.) for all research. Hispanic adolescents also surveyed.
  - b. Research indicates that adolescents universally see social influences as the primary reason for underage smoking.
  - c. Overall reaction to "Right Decisions, Right Now" advertising is very positive due to situational relevance (e.g., depicts real-life situations) and "non-preaching" tonality.
  - d. Adolescents see the advertising as a potentially effective way to address peer pressure by getting them to a) think about reasons why you shouldn't smoke; b) reinforce their own self-esteem and decision not to smoke; and c) reconsider prevalence by acknowledging that most kids don't smoke.
  - e. Research indicates that a significant campaign strength lies in its "tolerant" approach to the issue. Specifically, many adolescent know friends/family members who smoke. They do not see RJR executions ad degrading to these individuals or unrealistically depicting smokers as stupid. In essence, the campaign doesn't "preach" or talk down to them.

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f. Quantitative survey among 108 12- to 15-year-olds indicates the following:

- 84% see RDRN ads as interesting; 93% feel they are a good idea and 83% like the ads.
- 80% see the RDRN ads as better than or the same as other anti-smoking ads they've seen; 29% think RDRN ads are better than other anti-smoking ads.
- More than 95% feel the ads are sponsored by an anti-smoking agency or the government; less than 5% thought a tobacco company may be the sponsor.
- 93% think it would be a good idea to put the ads in their school.
- 69% said the ads made them dislike smoking more than before. Not one adolescent said the ads made smoking look appealing or made them feel better about smoking.
- 70% felt the ads were designed for people their age.

2. Parent reaction to "Right Decisions, Right Now" Advertising.

- a. While adolescents tended to favor the RDRN campaign because of situational relevance, parents tend to see the "peer pressure" approach as being potentially effective. Most parents believe peer influence to be responsible for a variety of adolescent behavior problems. Moreover, most parents acknowledge that their children are universally aware of the health risks of smoking.
- b. Parents are shocked to learn that the RDRN campaign is sponsored by a tobacco company. While some parents see the effort as a attempt to address external pressures on the industry, the overriding consensus is that the effort is responsible, potentially effective and should continue. Regardless of RJR's motive(s), parents think the children will benefit from the effort.

8. Parent-Directed Primary Research

1. Adult-directed communications seen by parents as a) reinforcing top-of-mind awareness that parental guidance is a key factor in initiation and b) reminding parents that they must communicate with their children on an array of issues.
2. Parents applaud the "How To Talk To Your Kids About Not Smoking Even If You Do" booklet as being proactive and responsible. Smoking parents overwhelmingly agree that the booklet would help them discuss not smoking with their children - many felt they couldn't bring it up without such a booklet.

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### C. Research Among Tobacco Retailers

1. Conducted extensive interviews with numerous retailers, chains and trade associations across the country to determine what materials would be necessary to improve minimum-age compliance in their stores.
2. Retailers/trade associations played an integral part in developing specific components of the "Support The Law" program.
3. "Support The Law" materials were screened by store clerks in several locations prior to retailer approval.
4. Subsequent presentation of "Support The Law" to retailers/chains/trade associations across the country has resulted in unanimous endorsement of the program and materials.

## VI. PROGRAM PARTICIPATION RATES

### A. "Right Decisions, Right Now" Program

#### 1. Youth-Directed Program

- a. In-School Advertising Materials: In-school materials (posters/tent cards) currently in use in over 100 cities (approximately 1,400 middle schools). Have distributed 75,000 - 100,000 posters in these schools to date. Also, book covers with "Right Decisions, Right Now" advertising are being distributed to over 1 million middle school adolescents.
- b. Teacher Study Guides & Training Materials: Study Guides from Lifetime Learning Systems are distributed to approximately 2.3 million middle school students. Additionally, 1 million students will receive the RDRN youth-directed brochure twice per year.
- c. Near-School Outdoor Advertising: Billboards on display in roughly 20 cities at near-school locations. Additionally, a school sign program - featuring RDRN ads mounted on street signs posted on school property - are currently posted at 350 schools (over a dozen cities) with significant expansion planned in 1993.

#### 2. Parent-Directed Materials

##### a. Brochures

- RJR has received 2,400 calls on the 800 number promoting information for parents on how to speak with their children about not smoking - "How To Talk To Your Kids About Not Smoking Even If You Do." Additionally, several thousand brochures have been distributed to interested school systems.

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- The Tobacco Institute has distributed more than 250,000 copies of "Tobacco: Helping Youth Say No." RJR has participated in this effort via 800 numbers in OOH/print.

b. Advertising

Billboards promoting the availability of parent brochures (with 800 number) are posted in roughly 20 cities. Moreover, RJR has run an adult-directed ad "Smoking Should Not Be A Part Of Growing Up" in dozens (35+) of newspapers/magazines nationwide. The ads have run in both English and Spanish.

B. Retailer-Directed Programs

1. "Support The Law...It Works!"

a. In-Store Training/Signage Program

Trade associations and chains representing over 15,000 - 20,000 stores have agreed to participate in the Support The Law program. Roughly 300 - 500 stores/week are signing up through Sales Force contacts, chain presentations and advertising. A complete list of participating retailers is available.

The program has been endorsed by several of the largest trade associations and retail chains. Press coverage of our announcement was generally positive.

b. Trade/Consumer Advertising

Ads promoting the availability of the "Support The Law" program have run in major trade publications (Convenience Store People, SIGMA, Progressive Grocer, etc.) and professional journals (The Advertiser, Governing, etc.). Circulation figures are available upon request.

RJR has run a series of consumer-directed ads urging communities to support age restriction laws. These ads have appeared nationally in USA Today.

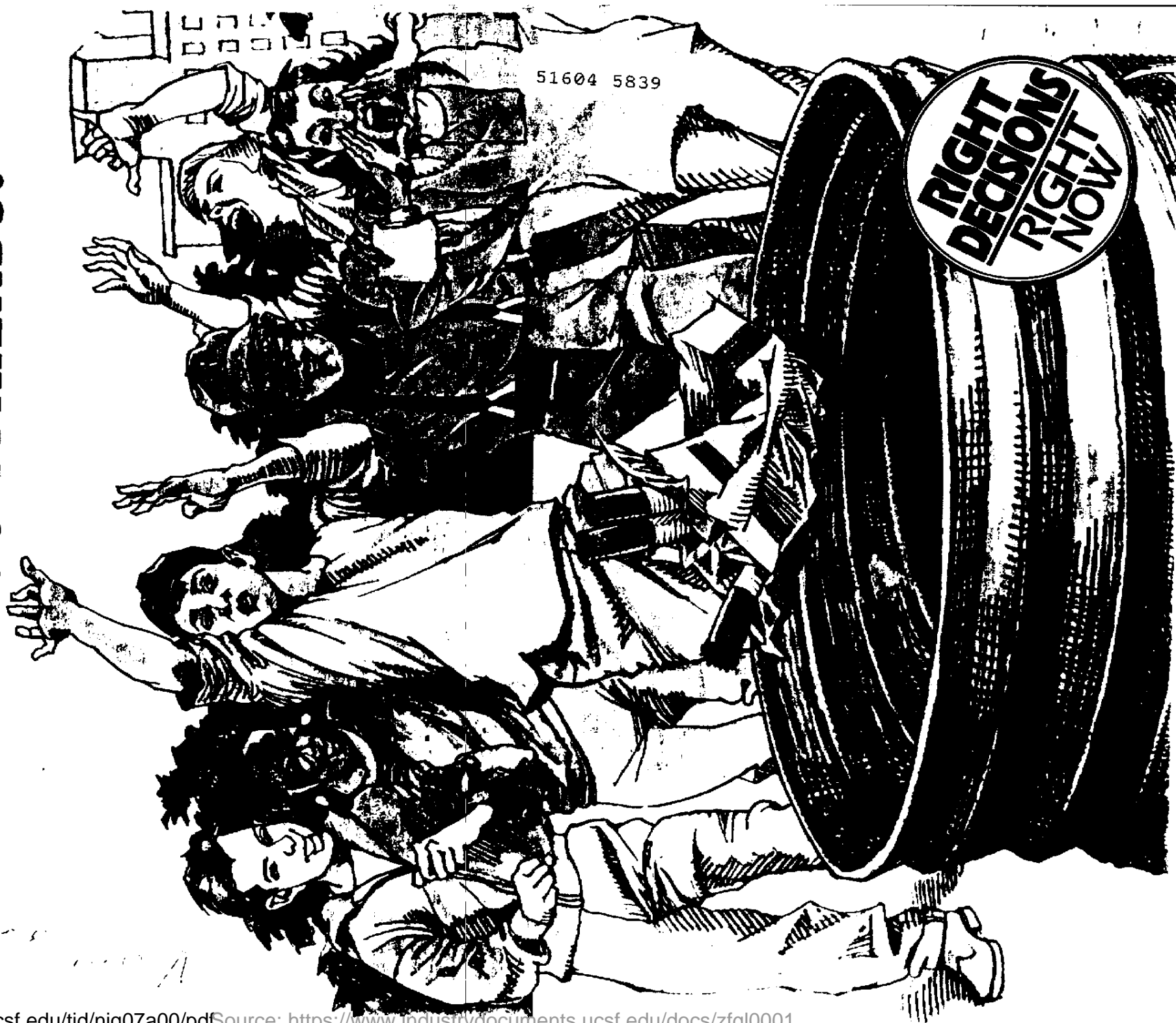
2. "It's The Law" (Tobacco Institute)

RJR has supported and executed the TI "It's The Law" program since its introduction in December, 1990. The program has been worked in ? outlets. Additionally, RJR is placing the "It's The Law" POS on all RJR overhead merchandisers at retail - 50,000 nationwide.

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**SHARE A GREAT IDEA  
WITH YOUR FRIENDS.**



# HOW CAN SMOKING BE THE THING TO DO, IF MOST OF YOUR FRIENDS AREN'T DOING IT?



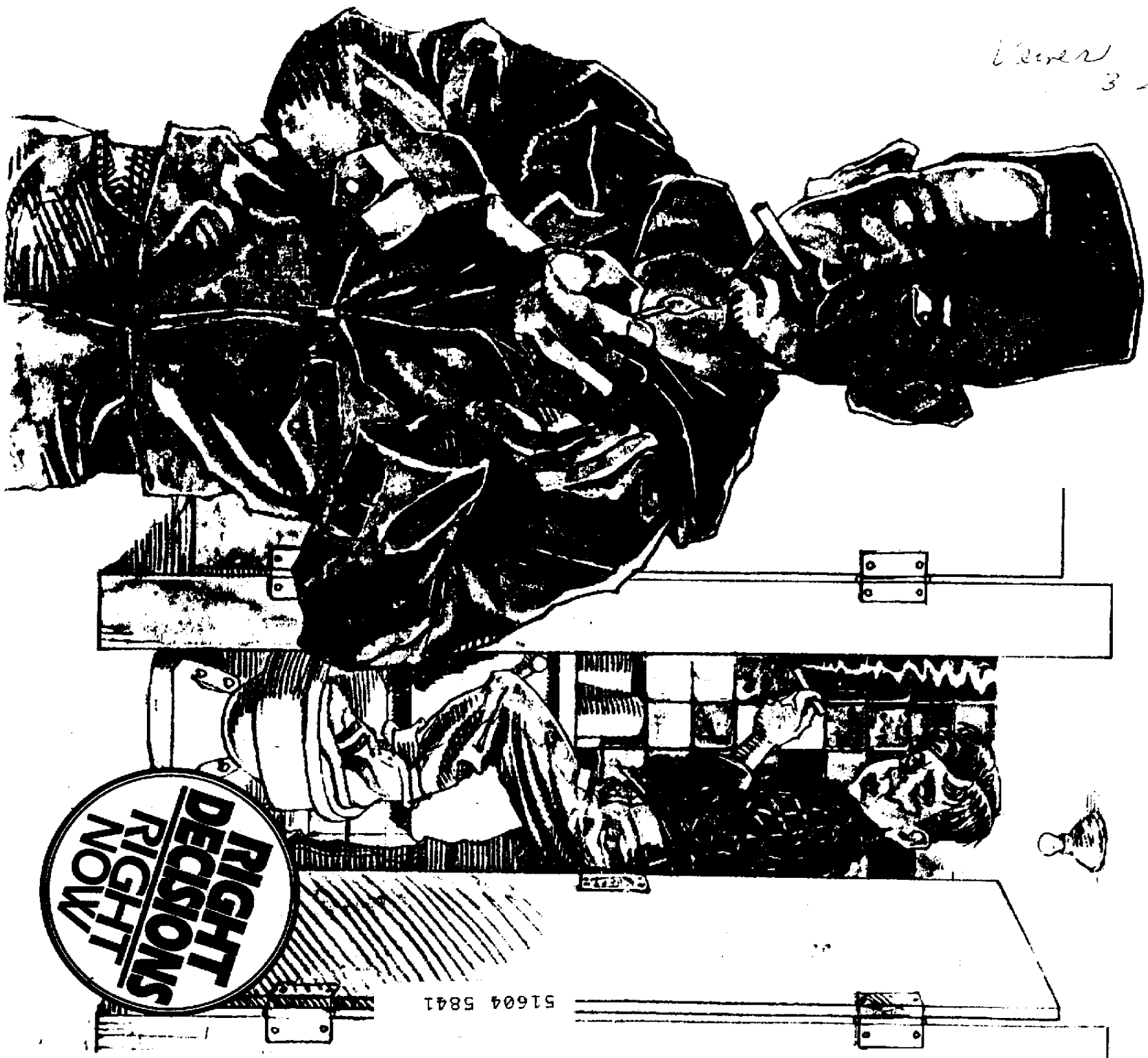
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FOR INFO, AS OF 5-22-97

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# AND YOU THINK THIS LOOKS COOL?



**DON'T CREATE  
A SMOKE SCREEN  
BETWEEN YOU AND  
YOUR FRIENDS.**



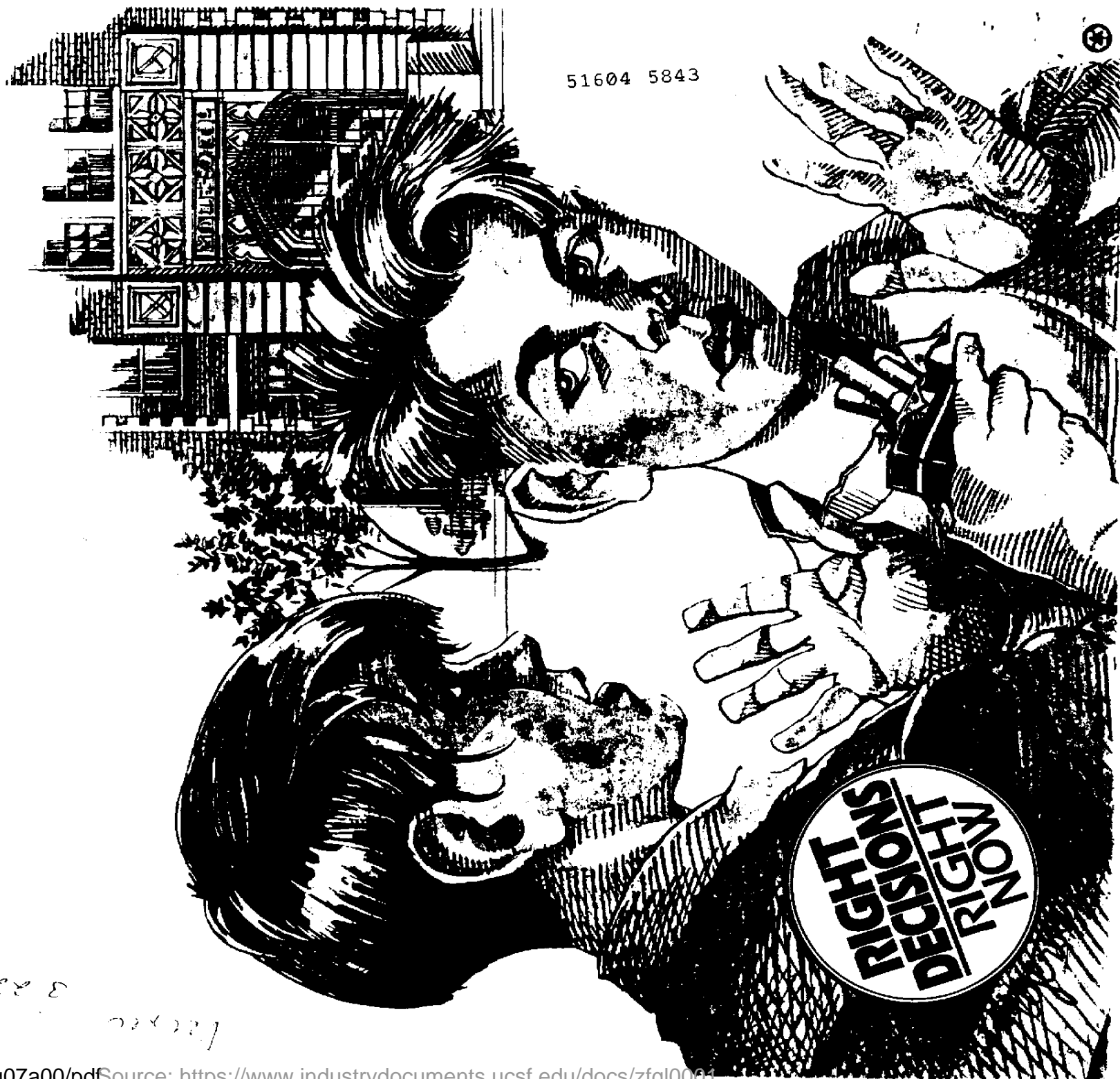
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Version 1.1  
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**THE CHOICE IS YOURS.  
DON'T BLOW IT.**

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**RIGHT  
DECISIONS  
RIGHT  
NOW**



**SMOKE SIGNALS MAY NOT BE  
THE WAY TO GET  
YOUR MESSAGE ACROSS.**



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**RIGHT  
DECISIONS  
RIGHT  
NOW**

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**AND YOU THOUGHT  
YOU KNEW WHAT IT  
TOOK TO FIT IN**



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**RIGHT  
DECISIONS  
RIGHT  
NOW**



**IF YOU'RE COUNTING ON  
SUPPORT FOR YOUR SMOKING,  
COUNT AGAIN.**



**IF SMOKING MADE YOU  
MORE ATTRACTIVE,  
YOU'D LOOK BETTER DOING IT.**



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*Verne* SEP. 22  
FOR ID. AS OF 3-22-97

# WANT TO BE IN? SMOKING CUTS YOU OUT.



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**RIGHT  
DECISIONS  
RIGHT  
NOW**

3-22-97  
**YOUR BIG IDEAS ABOUT  
SMOKING ARE A LOT SMALLER  
THAN YOU THINK.**



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**RIGHT  
RIGHT  
RIGHT  
NOW**



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*Verma*  
DEP. EX. NO. 25  
FED. AS CT 3-22-97

**HOW ARE YOU GOING TO FEEL  
IF THEY'RE NOT SMOKING?**

**IF YOU THINK SMOKING  
MAKES YOU FIT IN...  
THINK AGAIN.**

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# **Strategies To Control Tobacco Use In the United States:**

a blueprint for public health  
action in the 1990's

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Public Health Service  
National Institutes of Health  
National Cancer Institute

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Joseph W. Cullen, Ph.D.  
1936-1990

*The Smoking and Tobacco Control Monographs are dedicated to the memory of Joseph W. Cullen, former Deputy Director of the Division of Cancer Prevention and Control and architect of the National Cancer Institute's Smoking and Tobacco Control Program (STCP). Through his innovative leadership, the*

*STCP has now established itself as the world's premier organization in the field of smoking and tobacco use control.*

*Dr. Cullen was an inspiration to all who knew him, representing public service at its best. His untimely death in November 1990 represents a loss to us all, but most important, a loss to the public health of this country.*

Peter G. Greenwald, M.D., Dr. P.H.  
Director  
Division of Cancer Prevention and Control  
National Cancer Institute  
November 1991

# Strategies To Control Tobacco Use In the United States:

a blueprint for public health  
action in the 1990's

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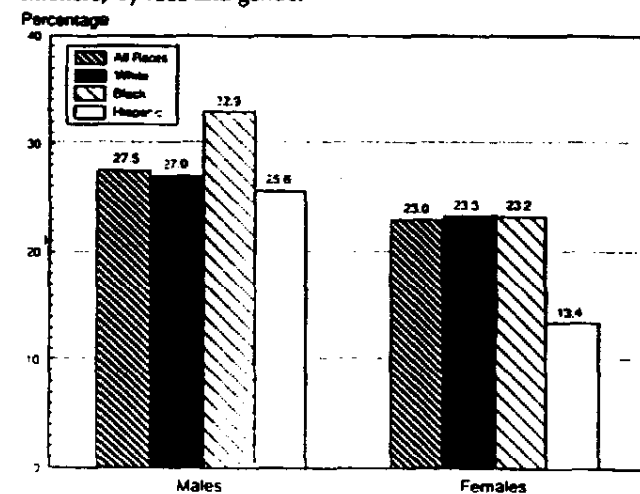
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Public Health Service  
National Institutes of Health  
National Cancer Institute  
NIH Publication No. 92-3316  
October 1991

## Foreword

Of all the U.S. Public Health Service agencies, the National Cancer Institute (NCI) has perhaps the longest history of involvement in the battle against the health consequences of smoking. During the early 1950's, when the first studies to link smoking with increased lung cancer risks were published, the Institute included smoking as part of its research agenda.

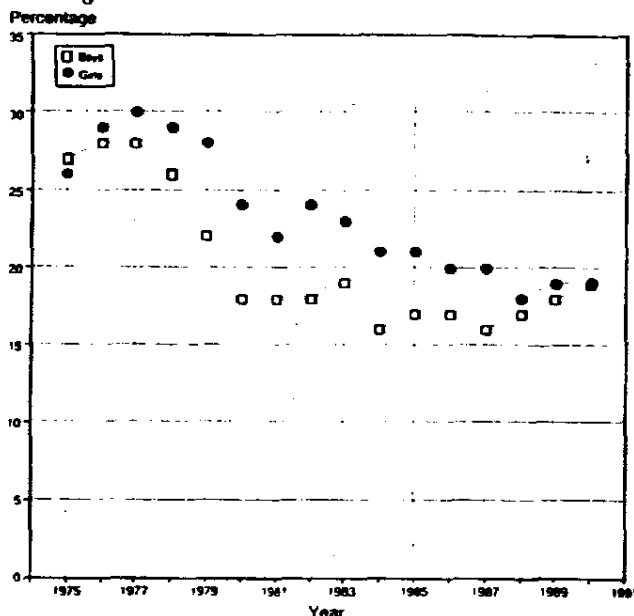
In 1955, NCI epidemiologists Haenszel, Shimkin, and Miller conducted the first large-scale national survey to assess patterns of tobacco use among adults in the United States. Theirs was a landmark study in many ways, not the least of which was its momentum against the prevailing indifference—and even hostility—in the medical community with regard to inferences that smoking harmed people. That study clearly defined the extent of the smoking problem in American society; nearly 60 percent of men and 28 percent of women were classified as current smokers at the time of interview. Since that time, substantial progress has been made in reducing smoking prevalence. Today, only about 25 percent of adult Americans report that they are cigarette smokers.

Figure 1  
Percentage of adults (age 18 and older) who are current smokers, by race and gender



Source: Current Population Survey, 1979

Figure 2  
Percentage of high school seniors reporting daily cigarette smoking



Nevertheless, nearly 50 million of our citizens are still using cigarettes regularly; and, sadly, the percentage of women who smoke is about the same now as was reported 35 years ago. Indeed, as a direct consequence of smoking, the age-adjusted death rate from lung cancer among women has increased by a staggering 420 percent during this same period. Further, smoking among black men is 20 percent higher than that reported by whites, and black men have the highest lung cancer mortality rate of any demographic group in the United States.

Even more discouraging, smoking among our children has not declined appreciably over the last decade, despite the continuing efforts of public health officials (Figure 2). Approximately 3,000 teenagers take up the habit each day.

The reasons for these developments should not be too surprising, as detailed in this monograph (see Chapter 1). Smoking is a pervasive social problem of gigantic proportions. Last year alone, this Nation consumed 527 billion cigarettes, or

2,828 cigarettes for every person 18 and over, smokers and nonsmokers alike (see Chapter 3). Cigarettes represent a unique class of commercial product in that they are life-threatening when used as intended by the manufacturer.

While this Institute spent \$47 million last year to develop and disseminate effective smoking intervention technologies, the major cigarette manufacturers spent \$3.6 billion in an effort to convince people that smoking is necessary for social acceptance, that it makes one attractive to the opposite sex, and that it enhances self-image. Over the past 4 years alone, expenditures for all cigarette advertising and promotional activities have increased nearly 50 percent and, increasingly, they appear to be targeting youth.

Perhaps the most criticized campaign of recent years was the introduction, in 1988, of the "smooth character" cartoon, Joe the Camel (Figure 3). In 1989, RJR Nabisco ran a particularly outrageous four-page ad in youth-oriented *Rolling Stone* magazine, in which dating advice was offered for young men. On the first page of the ad is a cartoon of a beautiful woman

Figure 3  
The "smooth character"



asking if the male teen is "bored? lonely? restless?" Inside, the "smooth character" gives "foolproof dating advice" for impressing someone at the beach:

Run into the water, grab someone and drag her back to the shore, as if you've saved her from drowning. *The more she kicks and screams, the better* [emphasis added].

While the tone and slant of this advice constitute an insulting provocation to the women of our country, perhaps equally troubling is the information on the back page of the ad: "How to get a FREE pack even if you don't like to redeem coupons." The suggestion: Just ask "your best friend" or "a kind looking stranger" to redeem the coupon for you.

Who is really the target of such an advertisement? Certainly, the camel cartoon character could not have much appeal for an adult. And how many people would feel compelled to ask "a kind looking stranger" to redeem a coupon for free merchandise—unless, of course, they were underage?

No doubt the success of the "smooth character" campaign is one reason that RJR Nabisco more than tripled its advertising expenditures for Camel cigarettes. In the wake of Joe the Camel's popularity, Brown & Williamson Tobacco Corp. has begun test marketing of a penguin cartoon character to promote Kool cigarettes in billboards, magazines, and store displays. It is not difficult to imagine what impact such large-scale, youth-oriented promotions may have on the sale of these brands to teenagers. Unfortunately, by the time we resolve this question, millions of our young people already will have become addicted to cigarettes. While the economic costs to our future program of health care delivery will be staggering, the future human costs are beyond reckoning.

As public health officials, we must devise effective strategies to counter such seductive promotions, and we will not shy away from this mission. Yet, for every \$1 that NCI spends on research to combat smoking, the tobacco industry spends \$80 to promote the addiction. Where the cigarette manufacturers can offer free packs of cigarettes, cigarette lighters, and premiums such as attractive clothing, we can offer only warnings about the dangers of smoking and advice about how to quit.

As health professionals, we need to understand that smoking is not only an individual's problem, but also a societal problem—"a social carcinogen," as one prominent researcher characterized it. Also, it is a problem that can not be left solely to Government to solve. It will require the combined efforts of

all of us to achieve a tobacco-free society. I call upon the entire medical and public health community to become involved in the fight against this Nation's number one public health menace—cigarette smoking.

Samuel Broder, M.D.  
Director,  
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## Preface

In the months immediately after January 1964, when Surgeon General Luther Terry released the first official Government report on smoking and health, cigarette consumption in the United States declined significantly. It was only the second time since the turn of the century that publicity about the hazards of smoking had produced a reduction in cigarette use. At that time, many leaders in the medical and public health arena assumed that, by providing the public with straightforward information about the dangers of smoking, they could discourage large numbers of people from using cigarettes.

While the expected change in behavior did occur, it was far more limited than had been hoped—a reflection of the difficulty that individuals often experience when they attempt to alter a complex behavior such as smoking, especially one we now know to be addictive.

The recognition that information alone would not eliminate tobacco use shifted the focus to strategies directed to the individual. This focus presumed, erroneously as it turned out, that the major determinants of smoking behavior were centered within the individual rather than sociologic in nature. Subsequent research and natural observation clearly demonstrated that behavior change correlated with changes occurring in the smoker's social and economic environment. This recognition has led to the adoption of public health strategies that now address the smoker's larger social environment while simultaneously offering programs of assistance for the individual.

This volume provides a summary of what we have learned over nearly 40 years of the public health effort against smoking—from the early trial-and-error health information campaigns of the 1960's to the NCI's science-based ASSIST project (the American Stop Smoking Intervention Study for Cancer Prevention), which began in the fall of 1991. *Strategies To Control Tobacco Use in the United States: A Blueprint for Public Health Action in the 1990's* presents a historical accounting of these efforts as well as the reasons why comprehensive smoking control strategies are now needed to address the smoker's total environment and reduce smoking prevalence significantly over the next decade.

An important finding discussed in this monograph is how different populations were affected by and responded to the early 1950's media coverage about the dangers of smoking, in

contrast to the effects of more intensive and sustained efforts in the late 1960's (see Figures 8, 9, and 10 in Chapter 1). During the latter period, the Federal Communications Commission ruled that cigarette advertising was subject to the Fairness Doctrine, and it required that all radio and television stations provide significant air time for health organizations to counter commercial ads with messages against smoking.

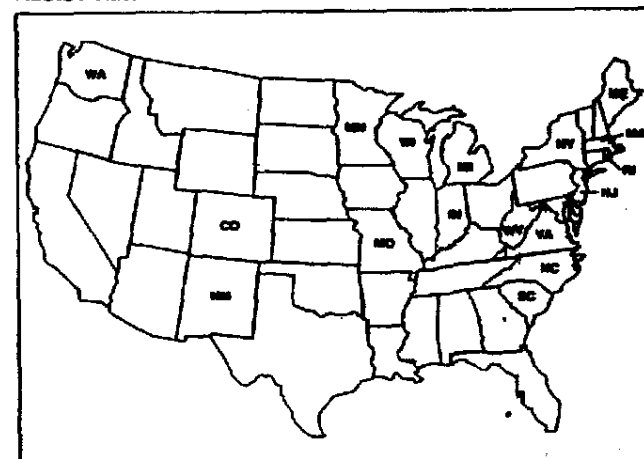
While the data show clearly that only white male smokers reacted to the first wave of public information in the 1950's—most likely because all of the early studies linking smoking and lung cancer were conducted with white males—the counteradvertising campaigns of the late sixties produced a greater level of smoking cessation across all major demographic groups. The TV and radio messages against smoking at that time employed broader themes and issues and thereby appealed to a more diverse audience. Further, the counteradvertising campaigns under the Fairness Doctrine used far-reaching electronic media—primarily television, while the public information of the middle 1950's had relied more heavily on print media.

The lessons gained from such natural experiments and from our contextual understanding of social factors that have influenced smoking in this century (see Figure 1, Chapter 5) are strong complements to our knowledge of what works—from the more than 100 controlled intervention trials sponsored by NCI in the 1980's.

Throughout the first 10 years of its existence, NCI's Smoking and Tobacco Control Program has operated under the philosophy that research, in and of itself, is not capable of producing large-scale national change in smoking prevalence rates. It was recognized from the outset that there must be a concerted effort to systematically and comprehensively apply the knowledge gained from the intervention trials. Thus, from its inception, the STCP has continually used information from such studies to plan the next steps for implementation of a national strategy to significantly reduce smoking in the 1990's.

The current state of the art in combating tobacco use combines multiple environmental changes with multiple programs directed to individuals in different stages of the smoking initiation and cessation process (see Figures 14 and 15, Chapter 1). This strategy recognizes that no single approach is best for all individuals, that no one intervention channel is capable of effectively reaching all smokers (or, in the case of children, potential smokers), and that no single time is best for individual smokers to make an attempt to quit. Comprehensive strategies for smoking control are characterized by

Figure 1  
ASSIST states



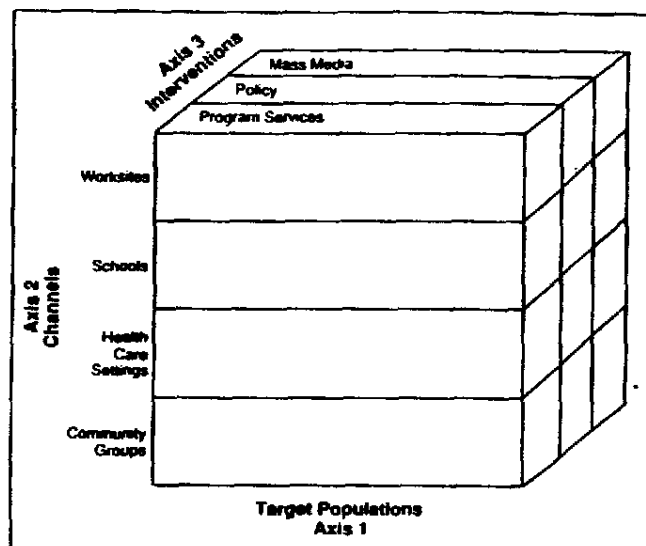
the delivery of persistent and inescapable messages to quit, or to not start smoking, coupled with continuously available support for individual cessation attempts, all provided through multiple channels and reinforced by environmental incentives for nonsmokers.

This strategy has provided the scientific foundation for the largest, most comprehensive smoking control project ever undertaken—the American Stop Smoking Intervention Study for Cancer Prevention. ASSIST is a large demonstration project designed to significantly reduce smoking prevalence in 17 states (Figure 1). Its primary objective is to reduce smoking prevalence to 15 percent or less by the year 2000.

The ASSIST framework incorporates a three-axis model, consisting of target populations, intervention channels, and interventions (Figure 2). The model organizes the multiple and diverse activities of a comprehensive smoking control initiative:

- **Target populations** (axis 1) can include youth, ethnic minorities, blue-collar workers, individuals with less education, women, or other populations with relatively high smoking prevalence.
- **Channels** (axis 2) are the organizational structures or mechanisms by which specific intervention activities will reach the target populations. In ASSIST, four major channels are envisioned as the primary means for contact with smokers and potential smokers.

Figure 2  
ASSIST conceptual framework



- **Interventions** (axis 3) are the instruments for producing change, both for the individual and in the larger community environment that will effect broader behavior change in target populations. In ASSIST, interventions will take the form of direct contacts with individuals and groups through a variety of program services, while media and tobacco control policies are expected to create broader social change and increase the demand for program services.

More than 90 million Americans will be directly affected by ASSIST over the life of the project. If ASSIST project goals are achieved, it will result in 4.5 million adults' quitting smoking and prevent 2 million children from ever taking up the habit. More important, a successful ASSIST project will have prevented nearly 1.2 million premature smoking-related deaths, including more than 400,000 deaths from lung cancer.

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## Introduction

In 1982, the National Cancer Institute began the Smoking and Tobacco Control Program (STCP). The STCP included a comprehensive research program for testing the efficacy of a variety of smoking intervention strategies. To date, nearly \$300 million has been allocated for this effort (Figure 1), making the STCP the largest program of its kind in the world.

**Figure 1**  
National Cancer Institute funding for smoking and tobacco control research

(in \$000's)

1982	10,943
1983	9,476
1984	16,721
1985	21,131
1986	27,099
1987	37,288
1988	39,604
1989	40,151
1990	41,500
1991	46,900
Total 1982-1991	\$290,813

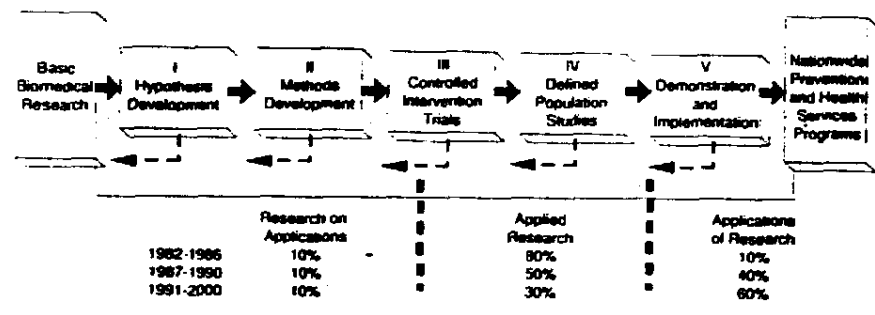
Source: National Cancer Institute

### STCP TRIAL AREAS

The priorities for STCP intervention research grew from a systematic planning process for cancer prevention and control that had already been developed within the National Cancer Institute. This early strategy positioned the control of smoking as the cornerstone for NCI's effort to reduce cancer mortality by 50 percent by the end of the 1990's. The strategy's blueprint was a model that defined NCI priorities for cancer control (Figure 2).

Priorities for STCP intervention activities evolved from state-of-the-art reviews and consensus development incorporating contributions from hundreds of scientists and public health experts. The result was the two-pronged strategy now in use. The first part involves the study of intervention methods that are school-based programs, self-help techniques, physician-delivered and dentist-delivered interventions, mass media

Figure 2  
Cancer control phases applied to smoking and tobacco control research



approaches, and community-based interventions. The second strategic arm targets specific populations that are (1) at greater risk for developing cancer and/or (2) amenable to prevention/cessation strategies. Included in the second strategy are youth, ethnic minority groups, women, smokeless tobacco users, and heavy smokers.

While nearly 100 separate intervention trials and studies now make up the NCI portfolio of smoking and tobacco use intervention research, 60 trials constitute the original core of the STCP program (Figure 3).

To aid in the national dissemination of STCP trial results, a series of monographs, of which this is the first, will be produced. This first monograph, *Strategies To Control Tobacco Use in the United States: A Blueprint for Public Health Action in the 1990's*, presents an overview of the components of an effective, comprehensive smoking control strategy. Future monographs will focus on individual trial areas or related topics.

Smoking and Tobacco Control Monographs are but one means that NCI uses for informing both the public health and research communities of emerging results from the smoking intervention trials initiated in the mid-1980's. While monograph contents will be based primarily on information and findings from NCI-funded trials and studies, they also will address various issues of importance to the public health community in the effort to reduce smoking-related disease. One important area, which recently has begun to receive increased attention, is that of policies and their effect on practices related to smoking and tobacco use.

#### SMOKING AND TOBACCO\* CONTROL MONOGRAPHS

Figure 3  
Smoking and tobacco control intervention trials

Goal: To develop and evaluate interventions to aid in either stopping or preventing tobacco use.

Number of Trials (1983-1987): 60

Intervention Areas	Number of Trials
School-Based Interventions	10
Self-Help Strategies	7
Physician/Dentist Interventions	6
Mass Media Interventions	5
Interventions in Black Populations	8
Interventions in Hispanic Populations	3
Interventions in Populations of Women	5
Control of Smokeless Tobacco Use	5
Heavy Smoker Interventions	11
<b>Total</b>	<b>60</b>

#### Purpose

In developing the concept for the Smoking and Tobacco Control Monographs, the Institute intended that the publications serve four major objectives:

1. Provide a cohesive and integrated description of individual smoking and tobacco issues, control strategies, and trial results to allow maximal utilization and dissemination of current and evolving knowledge and thereby influence the professional and layperson's understanding of these matters.
2. Significantly reduce the time between availability of information emanating from research projects and the publication and wide dissemination of this information.
3. Enhance the rapidity and efficiency with which NCI can utilize findings from research trials as a means of reducing cancer morbidity and mortality for those cancers most associated with tobacco use.
4. Provide a mechanism for codification and synthesis of information relevant to the use of those agencies, institutions, and individuals in the Nation that can affect the formulation of public policy related to smoking and tobacco use.

The rapidly growing understanding of what constitutes an effective strategy for controlling tobacco use has outstripped the ability of the peer-reviewed literature to disseminate this understanding to those responsible for implementing smoking

### Monograph Development Process

control programs. The limited space available in peer-reviewed journals and the relatively long lag time from the initiation of a study to the publication of its results are barriers to the rapid dissemination of new information and approaches to tobacco control. In addition, the dispersion of information on a given smoking control approach across multiple journals and different years of publication makes it very time-consuming and complicated to assemble a comprehensive picture of what is known about that approach. The Smoking and Tobacco Control Monographs are intended to aid in overcoming these barriers to information dissemination.

The major strength of the peer-reviewed literature and of Government reports on smoking, such as the Surgeon General's reports on the health consequences of smoking, has been the extensive review provided by individuals knowledgeable and experienced in the topic under examination. In establishing the editorial system for the STCP monographs, NCI has decided to adopt a process that relies extensively on input from the large number of talented researchers and program personnel currently working to reduce the burden that tobacco places on our society. The following summarizes the process for compiling the Smoking and Tobacco Control Monographs.

### Topic Selection And Outline

The staff of the STCP, in consultation with its support contractor and outside experts, develops a short list of possible monograph topics or ideas for consideration, and from that list a single topic is selected. The selection is based on program need, availability of data (both within and outside the program), public health importance, and other factors. The monograph's senior scientific editor develops a detailed outline and transmits it to Institute staff along with a list of candidate authors for individual sections and chapters.

### Scientific Content Development

Individual authors are recruited to produce draft manuscripts. Because the monograph content is based primarily on NCI-supported intervention trials, the majority of authors are STCP principal investigators. An editorial team is assembled, consisting of the senior scientific editor and consulting editors with expertise in the area under development.

Depending on the complexity and length of the proposed material, authors are asked to produce an initial draft manuscript between 90 and 120 days after accepting their writing assignments. During this time, the authors are encouraged to discuss any problems of content, focus, or style with the monograph editorial team.

After the initial drafts are produced, a 1-day working meeting of all monograph participants (authors, editors, and STCP and contractor staff) is convened. During that meeting, each author is provided with specific comments and suggestions.

### Peer Review

Approximately 60 days after the initial meeting, a second meeting of participants is convened, and final suggestions are provided. Within 30 to 45 days after the second meeting, a final version of each manuscript is delivered to the Institute. The individual manuscripts are then edited and consolidated into chapters by the Smoking and Tobacco Control Monograph editors.

All manuscripts are subjected to a two-tier peer review process. This process includes chapter reviews, whereby two or three experts in each subject area are asked to provide a critical review. Concurrent with the first review, a second peer review is conducted, involving senior scientists—individuals who have a long history of involvement in smoking control. These individuals are sent the entire monograph manuscript. Comments and criticisms from both groups are incorporated into the document by the scientific editorial team in collaboration with STCP staff.

### The First Volume

This monograph was the work of dozens of individuals—STCP trial investigators, public health and smoking control experts, and scientists and experts from other disciplines.

The monograph is organized into six chapters:

- Chapter 1—The Scientific Rationale for Comprehensive, Community-Based, Smoking Control Strategies
- Chapter 2—Evolution of Smoking Control Strategies
- Chapter 3—Smoking Prevalence and Lung Cancer Death Rates
- Chapter 4—Approaches Directed to the Individual
- Chapter 5—Approaches Directed to the Social Environment
- Chapter 6—Interdependence and Synergy Among Smoking Control Activities.

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## Chapter 1

# The Scientific Rationale for Comprehensive, Community-Based, Smoking Control Strategies

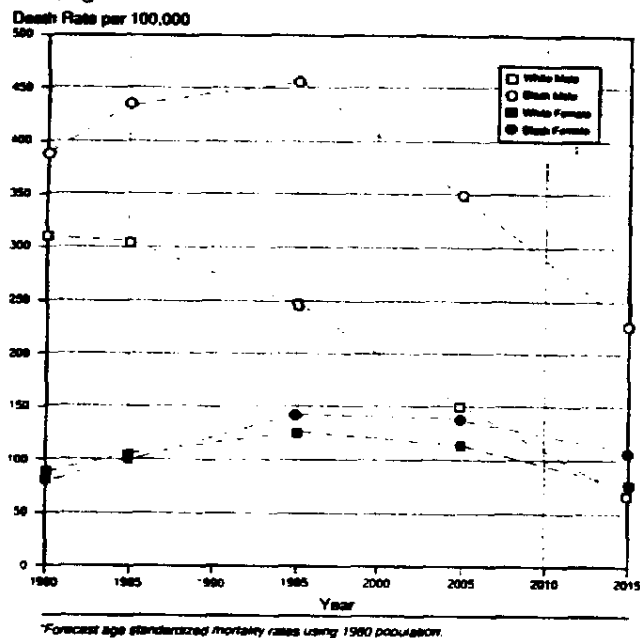
### INTRODUCTION

The use of tobacco predates the discovery of the New World by Columbus, and tobacco was one of the major cash crops of the early American colonies (Robert, 1967). Efforts to control tobacco use have a history almost as long and colorful, including King James I's "Counterblaste to Tobacco" in 1604 (International Agency for Research on Cancer, 1986). However, in the last century the use of tobacco has become more widespread and more hazardous. The development of machines that could manufacture cigarettes in the late 1800's and safety matches at the turn of the century set the stage for mass marketing of cigarettes. This mass marketing of cigarettes in the United States resulted in a rapid rise in per capita cigarette consumption that began around 1910 and provided one of the first demonstrations that advertising could create demand for a product where no previous demand existed (Whelan, 1984).

Coincident with the increasing use of cigarettes was a change in the tobaccos used to manufacture U.S. cigarettes (International Agency for Research on Cancer, 1986). The smoke from those tobaccos was milder and easier to inhale and had a pH that prevented absorption of nicotine across the oral mucosa; users had to inhale the smoke into the lung to absorb substantial amounts of nicotine. The deep inhalation of tobacco smoke, with the subsequent deposition, retention, and absorption of the smoke's toxic and carcinogenic substances, dramatically changed the risks associated with tobacco use and resulted in the proliferation of lung cancer and other smoking-related diseases.

During the 1930's and 1940's, the rapidly rising rates of lung cancer in men led scientists to investigate possible causes of the epidemic, using the newly developed tools of case-control and cohort epidemiologic studies. By the mid-1950's, data from these studies allowed the scientific community to conclude that cigarette smoking clearly was hazardous to health (Study Group on Smoking and Health, 1957), and the public health community began its continuing effort to reduce the burden of tobacco-related disease by reducing smoking initiation and promoting smoking cessation.

Figure 1  
Actual (1980) and projected (1985 to 2015) lung cancer death rates, ages 55 to 84\*



The rapid rise in lung cancer death rates during this century can be closely linked to the rise in cigarette consumption by men and women of both black and white races. A model presented later in this volume (Chapter 3) predicts future lung cancer death rates based on the recent and projected future changes in smoking prevalence (see Figure 1). This model predicts that changes in smoking behavior that have already occurred will produce a decline in the lung cancer death rates for white males within the next decade, but the rates for women and for black males would not be expected to fall until after the year 2000. This prediction is based on a continuation of the current trends in smoking behavior. If the rate of smoking cessation can be increased, then an even more substantial fraction of the expected mortality from lung cancer can be averted. The comprehensive strategies for controlling tobacco use described in this volume offer the best hope of reversing and ultimately eliminating the epidemic of lung cancer that has characterized this century.

#### BACKGROUND: EFFORTS TO CONTROL TOBACCO USE

This volume synthesizes what has been learned in the past 40 years of efforts to control tobacco use. As with most successful public health efforts, the current state of the art in control of tobacco use is built on a broad base of scientific investigation and includes the equally broad experience of successful and unsuccessful program activities that evolved in parallel with our scientific knowledge (Cullen, 1989).

Frequently, it is the operational experience with what works or does not work at the programmatic level that forms the core of interventions tested in controlled scientific investigations. It should come as no surprise, therefore, that current concepts of effective approaches to controlling tobacco use frequently outstrip both the tools needed to evaluate them and the data needed for definitive proof of their impact (US DHHS, 1990a). This volume presents our current best judgment of what constitutes an effective, comprehensive strategy to control tobacco use, and it draws extensively, and without apology, on the broad bodies of understanding developed by both controlled scientific investigation and the trial-and-error experience of interventions conducted in the community (Schwartz, 1987; US DHHS, 1990a).

The clear identification of cigarette smoking as a major health risk led to efforts to persuade current smokers to quit and to keep new smokers from beginning. Early approaches relied heavily on providing information about the risks of smoking (see Chapter 4). Although the impact of information campaigns was demonstrated by an increased awareness of smoking-related health risks and a decline in per capita consumption of cigarettes in the population at the time of the campaigns, it rapidly became apparent that information alone would not solve the problem. Knowledge of the health risks of smoking was transmitted to smokers and is probably a major motivational force in cessation attempts, but the vast majority of these cessation attempts failed, leaving most smokers wanting to quit but unable to do so.

In assessing the limited success of the educational campaigns against smoking, it is important to recognize that these campaigns were not presented in isolation (Schwartz, 1969). Rather, they were confronting the tobacco companies' much larger effort to promote smoking and to confuse the public about the risks of tobacco use (Whelan, 1984). In contrast to other health-based information campaigns, the effort to provide information on the risks of smoking was, and is, conducted against the backdrop of a multibillion-dollar advertising and promotional campaign that encourages cigarette smoking (Centers for Disease Control, 1990; Davis, 1987).

The tobacco industry responded to the initial burst of information on the risks of tobacco use with a combination of (1) a media effort designed to cast doubt on the level of scientific certainty about the risks and (2) a series of modifications to cigarettes (filters and lower tar content) designed to convince the public that the risk had been removed. It is not known how effective the antismoking public information campaign might have been if it had been delivered in the absence of the tobacco industry's much larger, competing campaign (Warner, 1977).

The recognition that information alone would not eliminate tobacco use shifted the focus of control strategies to the individual; programs were developed to help adults in their efforts to quit smoking and to prevent adolescents from beginning to smoke (see Chapter 4). The goal of these programs was to create psychological change within the individual that would enable successful change in smoking behavior and resistance to environmental stimuli that induce the start of smoking or a return to the practice after quitting. This focus on the individual presumed that the major determinants of smoking behavior are within the individual, a premise that turned out to be faulty, in part because many of the forces that promote smoking initiation and smoking cessation are sociological in nature rather than purely psychological. Also, the difficulty of attracting smokers and the limited resources for behavioral change that many smokers bring to such programs predict a very limited impact for individual-centered approaches relative to population-wide programs.

To broaden the appeal of individual-centered approaches, self-help programs and telephone hotlines to counsel smokers were developed (Glynn et al., 1990). These strategies did, indeed, attract a larger fraction of the smoking population, but their less intensive methods are also less effective at creating behavioral change by the smoker, leading to a lesser individual effect on a larger number of smokers.

Research on the determinants of smoking behavior and the observation that declines in cigarette consumption corresponded to changes in smokers' social and economic environment (Warner, 1977) led to a recognition that a focus on the larger social environment, rather than on the individual, could be an effective strategy for controlling tobacco use (see Chapter 5). Environmental changes that are believed to influence smoking initiation and smoking cessation include

- Increased tobacco costs;
- Antitobacco media campaigns;
- Declining social acceptability of smoking;
- Limitations on where smoking is allowed; and
- Restricted access for minors.

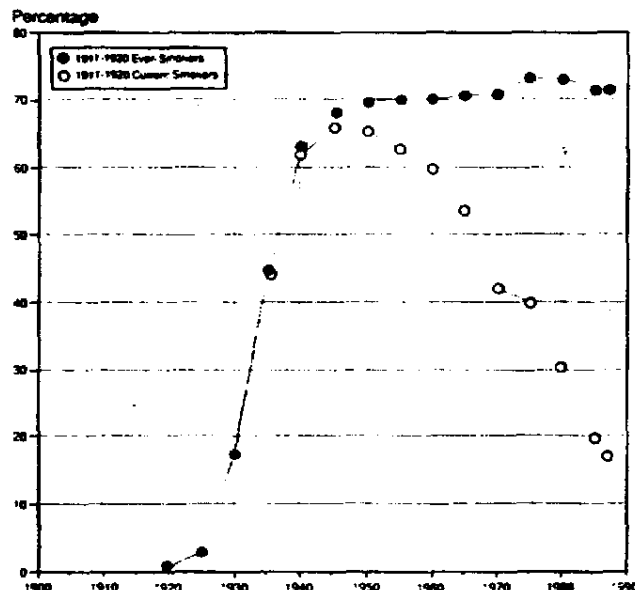
The impact of these changes is diffuse and, therefore, difficult to link to any change in the smoking behavior of an individual. However, the underlying premise of these social environment-centered efforts is that removal of environmental stimuli and reinforcements for smoking and the simultaneous creation of environmental disincentives for smoking markedly alter the personal psychological and sociological utility of smoking. This leads to higher rates of smoking cessation and lower rates of smoking initiation. If barriers to smoking are raised, the social reinforcement of smoking changed to social disapproval, and the smoker continually bombarded with messages to quit, then it is less likely that adolescents experimenting with cigarettes will continue on to dependence, more likely that smokers will attempt to quit, and, once they have quit, less likely that they will relapse.

As efforts to control tobacco use began to incorporate these social environmental approaches, it was realized that the two approaches, individual and environmental, were not competing strategies, but that they could be combined in a way that might synergistically increase their effect on smoking behavior (see Chapter 6). The combination of changing the environment to discourage smoking while simultaneously providing resources to increase smokers' ability to control their own behavior has the potential to effect substantial, sustained, population-wide change in smoking behavior (Pomrehn et al., 1990-91). These changes in the individual and in the social environment often occur incrementally and at a modest pace. Therefore, smoking behavioral changes may lag behind changes in policies or social norms. Changes in the social environment would be expected to have a modest initial impact that increases with time as the social changes percolate through the environment in which the smoker lives.

As the basis for current, comprehensive, community-based efforts to control tobacco use, this combined approach recognizes that individual and environmental inputs can be provided at multiple levels, through multiple channels, and over a relatively continuous time. Persistent and inescapable messages to quit are provided to the smoker concurrent with repeated offers of support and assistance in the quitting process (US DHHS, 1990a).

The description of control strategies presented in this volume recognizes that there is no single solution to the problem of tobacco use. Different programs have impact on different points in the process of initiation, maintenance, and cessation of smoking behavior. More than one program may simultaneously influence an individual to alter smoking behavior, and a single program may have different effects on

Figure 2  
Smoking prevalence among men born from 1911 to 1920  
(through 1987)



individuals at different stages of smoking behavior. The recognition that smokers use the cigarette to interact and cope with their environment has led to current efforts to change both the smoker and the smoker's environment.

#### PATTERNS OF SMOKING BEHAVIOR

The prevalence of cigarette smoking is not uniformly distributed across the U.S. population. Cigarette smoking varies with age, gender, race, education, year of birth, and other factors (Pierce and Hatziaandreu, 1989). These differences are important for assessing the disease risks associated with tobacco use, and knowledge of these patterns is essential to the development of strategies to control tobacco use.

The initiation of regular smoking is confined almost completely to those under the age of 25, and 90 percent of cigarette-smoking initiation is complete by age 21 among current cohorts (Pierce and Hatziaandreu, 1989). Figure 2 shows the pattern of smoking initiation and cessation for men born in the years 1911 through 1920; initiation of smoking occurred only in early life, and the major change in smoking behavior after age 25 was cessation. This general pattern (smoking

initiation early in life and cessation later in life) appears among all subgroups of the population, but different subgroups have different rates and ages of initiation, achieve different rates of peak smoking prevalence, and have different rates of cessation (Harris, 1983). For instance, the rates of cessation are lower and prevalence of smoking is higher among individuals at lower socioeconomic levels and with lower levels of formal education (Pierce and Hatziaandreu, 1989). In addition, differences in the pattern of smoking behavior between black Americans and white Americans (see Chapter 3) include a much smaller decline in the prevalence of smoking among blacks (Flores et al., 1989).

Gender differences in patterns of smoking behavior are illustrated in Figures 3 and 4, which contrast the smoking behavior of men and women born during different decades of this century, from 1901 through 1970. The men born in the first few decades took up smoking early in the century and early in life and reached a very high peak prevalence of smoking. In contrast, the women born during the same periods began to take up smoking later in the century and consequently later in life, and they reached peak prevalence levels that were much lower than those of their male counterparts (Harris, 1983). The gender-related differences in smoking behavior among the cohorts born later in the century are far smaller, and the patterns of smoking behavior for men and women in the most recent birth cohort (1961 to 1970) are almost identical.

These differences in smoking behavior are important to the understanding of comprehensive strategies to control tobacco use because they explain the requirement for multiple channels and multiple interventions. Because of the diversity of smoking subgroups, no single approach should be expected to work for all smokers, and no single channel can be expected to reach all smokers.

The comprehensive strategies described in this volume are based on the premise that (1) specific programs to alter smoking behavior can be aimed at different points in the process of initiating, maintaining, and quitting smoking behavior and (2) a concerted effort to attack smoking behavior at each of these points will yield results far greater than those expected from the sum of the programs applied independently. Furthermore, there is an assumption that smokers must be reached within and by the structures where they live and work; therefore, a comprehensive strategy must include participation by a broad and representative selection of the groups and social structures that constitute the community in which the smoker lives (Thompson et al., 1990-91).

Figure 4  
Changes in smoking prevalence among U.S. females born from 1901 to 1970 (through 1987)

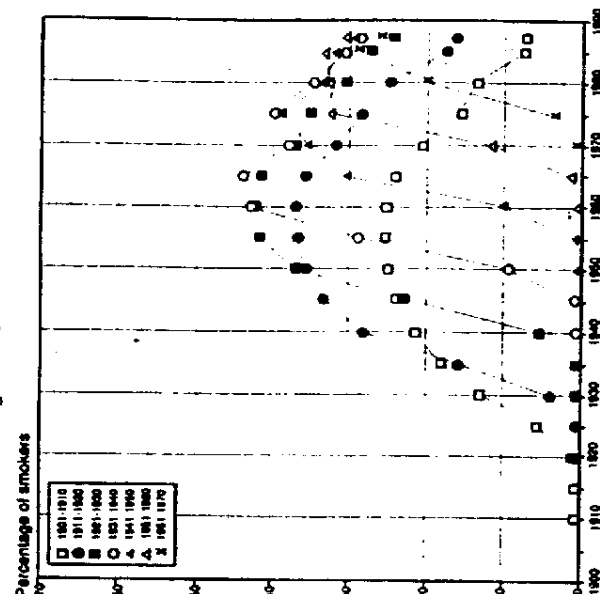


Figure 3  
Changes in smoking prevalence among U.S. males born from 1901 to 1970 (through 1987)

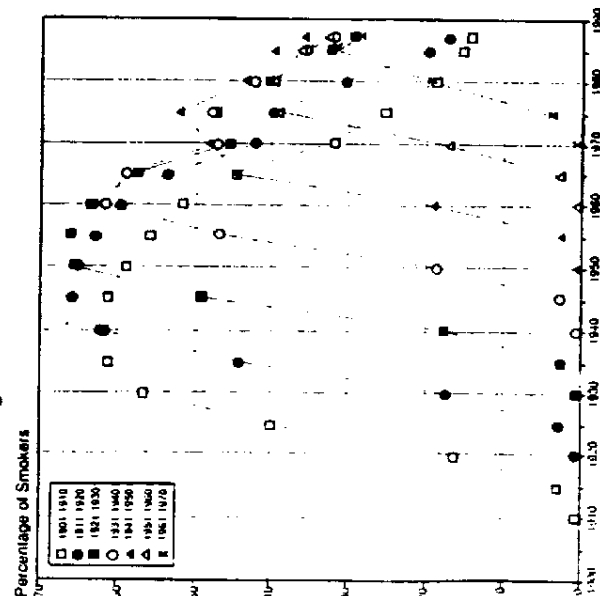
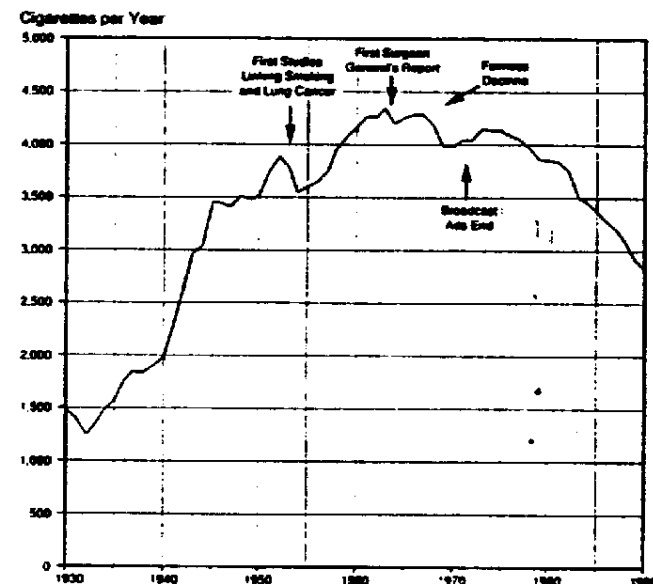


Figure 5  
U.S. per capita cigarette consumption for adults, aged 18 and older (1930 to 1990)



### ROLE OF PUBLIC INFORMATION CAMPAIGNS

One of the earliest responses to the scientific data that established the risks of smoking was an information campaign to communicate the health risks of cigarette smoking with the expectation that relaying the risk information to the smoking public would lead to changes in smoking behavior. Clearly, these information campaigns have been successful in communicating risk information at the simplest level: In recent surveys, more than 80 percent of current smokers agreed that smoking is harmful and even that it is harming them as individuals (Pierce and Hatzianidreu, 1989). Information campaigns have been less successful, though, at transmitting an understanding of the magnitude of the risks associated with smoking (Shopland et al., 1990).

The expected change in smoking behavior did occur, but it was far more limited than had been hoped (US DHHS, 1989), suggesting the individual smoker's difficulty with breaking his or her dependence on tobacco. Figure 5 shows the changes in cigarette consumption during this century and suggests the relation of such changes to media information campaigns. Per

capita consumption of cigarettes declined with each of these major informational events:

- A substantial downturn in consumption coincided with the lay media's presentation of scientific evidence establishing the risks of smoking in the mid-1950's.
- A smaller downturn occurred with the publication of the first Surgeon General's Report in 1964 (US DHEW, 1964) and the resultant media coverage.
- A major downturn in per capita cigarette consumption also occurred during the late 1960's; between 1967 and 1970, mandated antitobacco spots were shown on television to counter cigarette advertisements. When cigarette advertisements were banned from television in 1970, the bulk of the antitobacco advertising campaign also disappeared, and per capita cigarette consumption again increased.

Information alone is often dismissed as a means of influencing smoking behavior, but information about smoking-associated disease risks provides much of the motivational substrate for individual cessation efforts and is likely to trigger cessation attempts. It is clear, however, that these informational campaigns of themselves were unable to create and sustain cessation in the majority of smokers.

#### RESULTS OF EARLY TOBACCO CONTROL EFFORTS

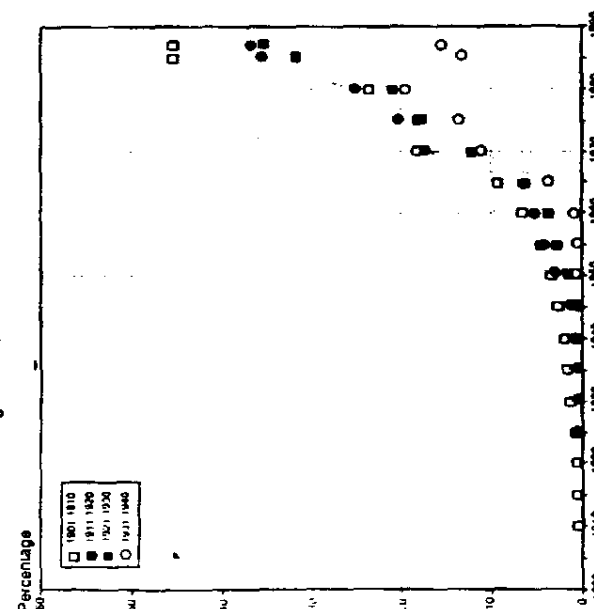
The decline in smoking prevalence over time within a given birth cohort has led to the suggestion that aging is the dominant influence on smoking cessation. But the attribution of cessation to advancing age ignores the fact that activities to control tobacco use have increased over the last four decades, concurrent with the aging of the individuals that make up the birth cohorts. By examining the changes in smoking prevalence for the four oldest birth cohorts of males, one can see that the point where smoking prevalence begins to decline in each cohort is in the mid-1950's, which suggests that events in the social environment influenced all of the different cohorts simultaneously, regardless of age. The four earliest cohorts are cited because men born later would not have completed the initiation of smoking by the time of the 1950's campaigns.

Figures 6 and 7 present these data more clearly, showing the percentage of former smokers in each of these four earliest cohorts of black and white men, plotted by calendar year. The percentage of former smokers among white males in the earliest cohorts begins to rise in the 1950's. There appears to be an effect of age, with the oldest cohorts having the highest percentage of former smokers, but all of the cohorts show steep rises in the proportion of former smokers during the 1950's and 1960's, which suggests that the major effect is related to calendar year rather than to age.

Figure 7  
Percentage of former smokers, white males born from  
1901 to 1940 (through 1987)



Figure 6  
Percentage of former smokers, black males born from  
1901 to 1940 (through 1987)





The change in the percentage of former smokers that occurs with calendar year is quite different for black males than for white males. Among the white males, a sharp upturn in the prevalence of former smokers begins in the 1950's and accelerates during the late 1960's. For black males, the prevalence of former smokers remains almost zero until the late 1960's. This difference between white and black males is even more evident when the fraction of smokers who have quit during each 5-year period (Figures 8 and 9) is plotted against the calendar year. Both black and white males show large changes in smoking prevalence during the period of counter-advertising on television (1967 to 1970), but only white males show a change in smoking behavior during the first wave of public information on the risks of tobacco use (in the mid-1950's), which relied much more heavily on print media.

The question of racial differences in source or timing of information transfer can be explored through comparison of the 5-year quit rates in the same birth cohorts of white women (Figure 10). The pattern in the white female cohorts is similar to that of black men rather than that of white men, with very little change in smoking behavior until 1965 to 1970. This suggests that the absence of an effect in black men corresponding to the early public information campaigns is not solely a racial phenomenon. The early studies of smoking-related disease risk were conducted largely with white males (US DHHS, 1982), so the absence of data on women and on black men may have prevented these groups from relating the risk information to themselves. On the other hand, the counter-advertising campaign of the late 1960's used messages and themes that addressed a range of issues in addition to health risks (Warner, 1977). This broader range of messages may have reached women and black males unaffected by the earlier health messages and may have been responsible for the greater level of smoking cessation in all racial and gender groups.

For all of the racial and gender groups, the rates of cessation plummeted when the antismoking spots were removed from television. This observation lends further support to the theory that the intensive media campaign against smoking had a profound effect on smoking behavior (US DHHS, 1989; Warner, 1977).

The provision of information to the smoker on the disease risks of smoking did not lead to successful cessation by the majority of smokers. The recognition that most smokers who wanted to quit were unable to do so on their own led to the development of programs that would produce change within smokers that would help them to break their addiction. The goals of these programs included providing smokers with the

#### Approaches to Influencing The Individual

Figure 9  
Percentage of white male current smokers quitting over 5-year  
intervals

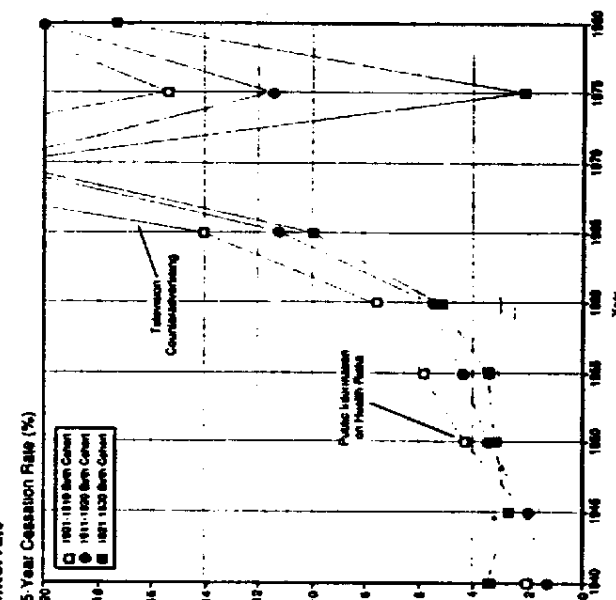


Figure 8  
Percentage of black male current smokers quitting over 5-year  
intervals

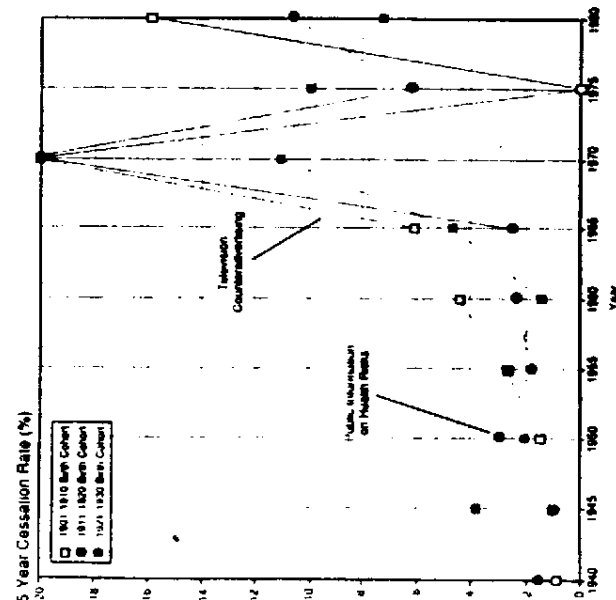
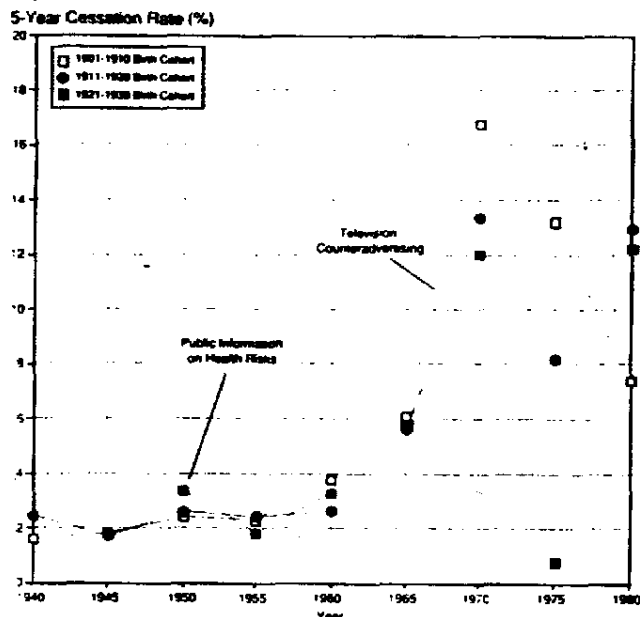


Figure 10  
Percentage of white female current smokers quitting over  
5-year intervals



tools to change their behavior, changing the behavioral conditioning surrounding smoking, and altering the coping strategies used by smokers (see Chapter 4). However, the common link in all of these approaches was the attempt to alter the individual so that he or she could make the desired change in behavior in spite of environmental influences that promote smoking.

It was believed that the individual could be strengthened and retrained to eliminate dependence on cigarettes, and the multicomponent programs described in this volume have demonstrated that it is possible to produce long-term cessation in a large proportion of smokers willing to complete these programs. The major problem with clinic-based cessation programs has been the difficulty of convincing smokers to participate. An overwhelmingly large percentage of those who successfully quit smoking, and an even larger fraction of those who attempt to quit, do not use a clinic-based cessation program but try to quit on their own (Fiore et al., 1990; US DHHS, 1990b).

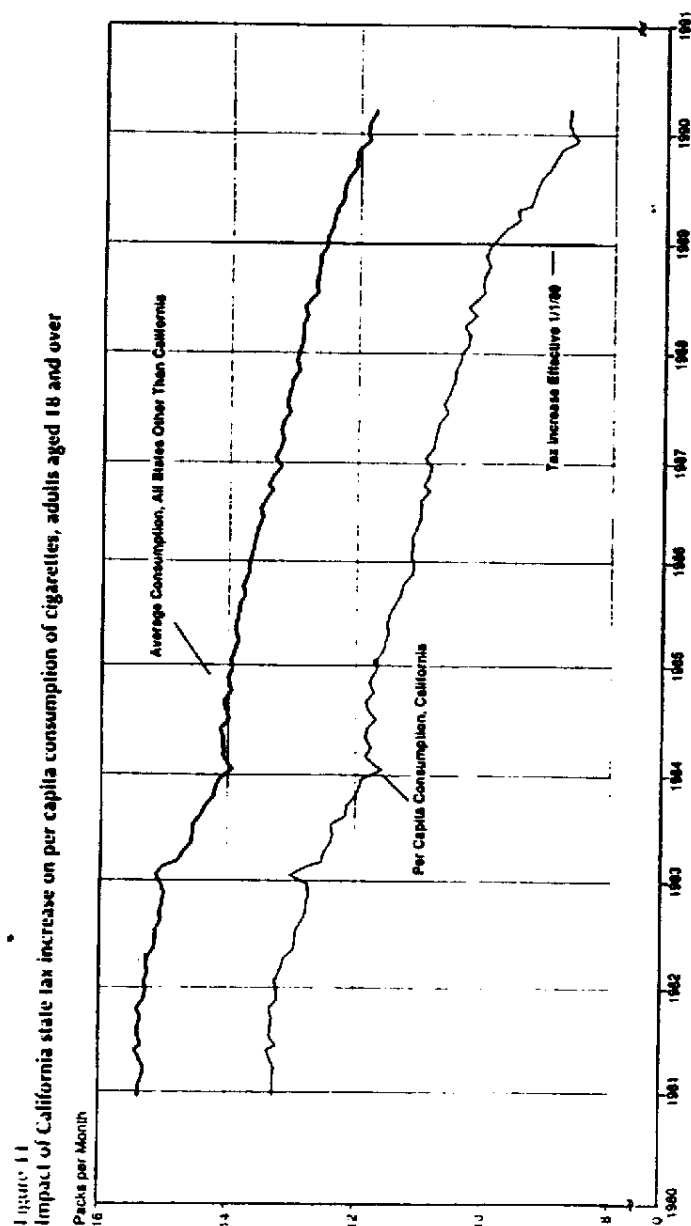
A companion problem has been program costs. One concept that emerges from evaluations of the various clinic programs presented in Chapter 2 is that the more intensive the program, the more likely it is to be successful. Programs with a greater number of sessions, professional rather than volunteer leaders, and more extensive followup and maintenance support show better results. As a result, the current state-of-the-art clinic-based cessation programs are expensive in time, energy, and dollars. The high costs for individuals, for insurance companies, and for health care providers are barriers to access.

It is unlikely, however, that cost alone is the major reason why clinic-based cessation programs get little use, since other, more expensive prevention efforts (such as diagnosis and management of essential hypertension) have enjoyed excellent results. It is more likely that the major limitation is the low demand for these programs by U.S. smokers. The long-term financial benefit for the individual and for society may outweigh the short-term cost, but those short-term costs, coupled with smokers' perceptions of little need for the programs, have markedly constrained the impact of clinic-based cessation programs on the prevalence of smoking.

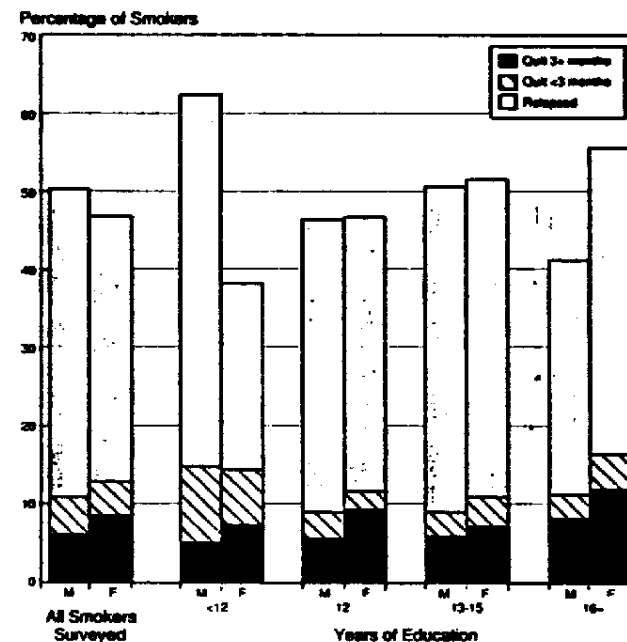
#### Approaches to Influencing The Environment

The limited impact of clinic-based cessation programs, together with growing recognition of the importance of environmental factors in smoking behavior, led to the shift in tobacco control strategies described in Chapter 5. The association of shifts in global measures of U.S. tobacco use, such as per capita consumption, with changes in the environment, such as the shrinking social acceptability of smoking, has led to attempts to alter those environmental factors as a means of altering smoking behavior.

Raising the cost of cigarettes as a public health strategy has been accomplished through increased excise tax on tobacco, and the manufacturers have also substantially increased the cost of cigarettes (Grise, 1991). As described in Chapter 5, increases in the excise tax have generally resulted in a substantial and immediate fall in cigarette consumption, but the effect dissipates with time (Tobacco Institute, 1990). The experience in California, which raised its excise tax on tobacco by 25 cents on January 1, 1989, is presented in Figure 11, wherein California's per capita cigarette consumption is contrasted with that for the rest of the United States (California Department of Health Services, 1990). There was a rapid decline in per capita consumption coinciding with the California tax increase that was not present in the rest of the country. Analysis of those data suggests that there was a 5 percent decline in per capita cigarette consumption attributable to the increase in the tax (J. Elder, personal communication).



**Figure 12**  
Smoking relapse rates, by gender and level of education  
(California smokers, 1990)



One concern about using cost as a strategy to control tobacco use has been that the resulting decreases in tobacco consumption may be transitory; they may reflect large numbers of smokers trying to quit around the time of the tax increase, then relapsing, with no long-term change in the prevalence of smoking in the population. Evidence to support this concern is provided by a survey of California smokers conducted 18 months after the 1989 excise tax increase (California Department of Health Services, 1990). Figure 12 shows the status of all those who had been smoking 12 months prior to the survey. About one-half of those Californians who had been smoking 12 months prior to the survey made an attempt to quit, in contrast to approximately one-third of smokers in national surveys. However, the fraction of those who were smoking 12 months previously and who currently had been nonsmokers for 3 months or more is no larger in California than in the national surveys. This suggests that the tax may

have stimulated an increase in the number of cessation attempts but not increased the number of smokers able to quit successfully.

Because the majority of current smokers began smoking before the age when it is legal to buy cigarettes in most states, the access of minors to cigarettes is seen as an important precondition for the initiation of smoking behavior (US DHHS, 1989). The disparity between the consequences of cigarette use and the availability of cigarettes to minors through legitimate channels is greater than for any other dependence-producing substance in our society. More than 80 percent of children are able to purchase cigarettes over the counter, and minors essentially have no difficulty buying cigarettes from vending machines (see Chapter 4). The fact that this country's single largest cause of death and disability is sold to children through unattended vending machines has galvanized legislators in an increasing number of jurisdictions to restrict or ban the sale of cigarettes through vending machines (Tobacco-Free America, 1990), and it has promoted efforts to educate merchants and enforce the law prohibiting sales to minors (US DHHS, 1990c).

The social acceptability of cigarette smoking has been declining since at least the early 1970's (US DHHS, 1989). This decline is based on concerns about the disease risks of exposure to environmental tobacco smoke as well as irritation and annoyance produced by exposure to others' tobacco smoke. By early 1971, the probability that environmental tobacco smoke exposure could cause a substantial disease risk had been clearly annunciated by then U.S. Surgeon General, Jesse L. Steinfeld, M.D. (Steinfeld, 1972). The body of scientific data on this topic that developed subsequently and the national reviews of those data (US DHEW, 1972, 1975, and 1979; US DHHS 1982 and 1986; National Research Council, 1986; U.S. Environmental Protection Agency, in press) have led to increasing restrictions on where smoking is allowed (Pertschuk and Shopland, 1989). Regulations that established separate seating areas in airplanes and restaurants and banned smoking in public places put smokers on notice that their behavior annoyed a substantial number of nonsmokers, and the new rules empowered those nonsmokers to express that annoyance. The outcome was a slow but steady erosion of the rewards of smoking and a change in the smoker's self-image. A large part of the smoker's dependence on the cigarette is conditioned by the personal psychological and sociological utility of smoking. Removing this utility undercuts the foundation of tobacco addiction.

A more recent outgrowth of the increasing concern about the risks associated with exposure to environmental tobacco smoke has been absolute bans on smoking at worksites, on airlines, and in other locations (Shopland et al., 1990) (see

Chapter 5). These bans reinforce the social unacceptability of smoking by incorporating it into the norms for workplace behavior, and they keep the smoker from smoking on the job. Eliminating smoking at work may prevent young smokers from learning to use the cigarette to deal with workplace stress and may give older smokers experience in coping with life stresses without cigarettes, thereby improving their chances for success when they try to quit smoking. In addition, a smoker who has quit may be less likely to relapse in a work environment where smoking is not permitted.

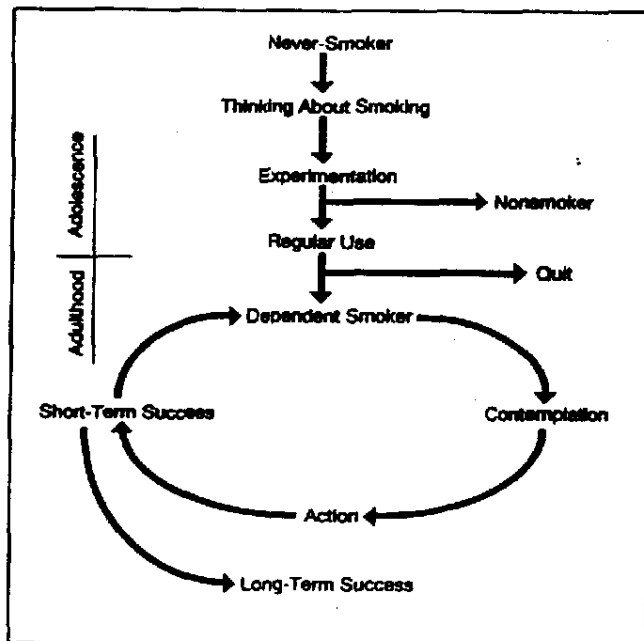
The specific relationship of advertising and promotion to smoking initiation and tobacco use is not clear, but it is clear that tobacco advertising presents images of smoking and smokers that are attractive to adolescents (Fischer et al., 1989). A concern is that the advertising images are most attractive to those adolescents with the least objective verification of their self-worth from their own social environment. This effect may explain the differences in smoking behavior between adolescents in school and adolescents who have dropped out (Pirie et al., 1988). The potential effect of advertising on the most vulnerable segments of society has led to efforts to restrict tobacco advertising and promotion at both national and local levels.

#### COMPREHENSIVE CONTROL STRATEGIES

As the focus of control strategies expanded beyond the individual to include the environmental factors described above, our understanding of smoking initiation and cessation also expanded. Researchers and health educators came to recognize that both smoking initiation and smoking cessation are dynamic, multistage processes, rather than linear, dichotomous events (Prochaska and DiClemente, 1986). It was also understood that smoking could be attacked at multiple stages in these processes and that different strategies could affect different stages with potentially synergistic outcomes. Programs that alter environmental influences, such as media campaigns, have proven much more effective when they are supported by resources to help individual smokers in their cessation efforts (see Chapter 5).

The current state of the art in controlling tobacco use combines multiple environmental changes with multiple programs directed to individuals in different stages of the initiation and cessation processes. It recognizes that no single approach is best for all smokers and that different smokers are most attracted to and most affected by different programs. Perhaps more importantly, it recognizes that no single channel reaches all smokers and that no single time is best for all smokers to make an attempt to quit. Comprehensive strategies are characterized by the delivery of persistent and inescapable messages to quit, or to not start, smoking, coupled with continuously available support for individual cessation efforts

Figure 13  
Processes of smoking initiation and cessation

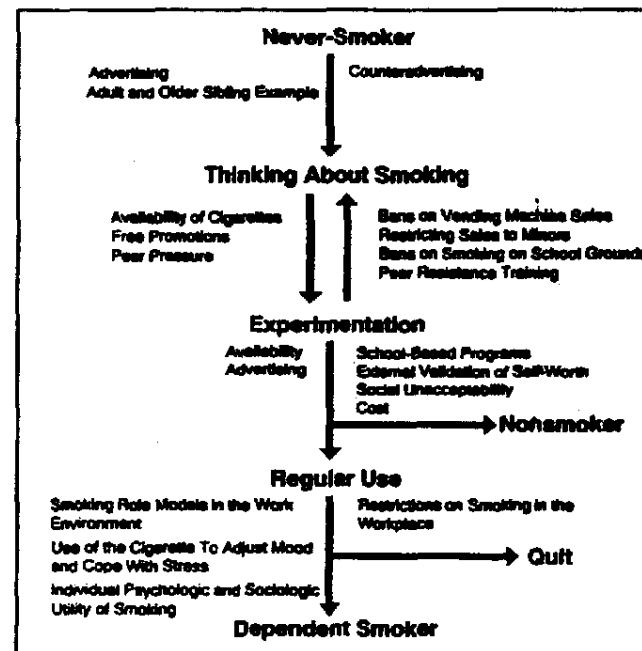


provided through multiple channels, and reinforced by environmental incentives for nonsmokers.

One formulation of the processes involved in cigarette initiation and cessation is presented in Figure 13. Exploration and initiation of regular cigarette use is largely confined to adolescents, with the transition from regular use to dependence during late adolescence and early adulthood. Experimentation with cigarettes and initial use is heavily influenced by issues that are active during adolescent development, whereas dependent use of cigarettes develops when smokers incorporate the personal psychological and sociological utility of smoking into the methods by which they function in and cope with the adult world. Many adolescents experiment with tobacco use but never become regular smokers, and some adolescent regular smokers stop before they become dependent on cigarette use.

The process of quitting smoking is often a cyclical one, with the smoker making many attempts to stop before finally

Figure 14  
Forces that influence adolescent progression into adult smoking



gaining success. About one-third of current smokers attempt to quit each year, but 90 percent or more of those attempts fail (Pierce and Hatziafreu, 1989). Clearly, those who have unsuccessfully tried to quit need to be motivated to try again. A useful conceptualization of the cessation process is one in which smokers cycle through the stages of cessation, and each time smokers go through the cycle, a few more succeed in their efforts to quit. One goal of control strategies, then, is moving smokers from one stage of the cessation cycle to another, rather than using long-term cessation as the only goal and outcome measure of a program.

#### Affecting the Initiation Process

The development of tobacco dependence is not sudden, and the process of initiating tobacco use is a gradual one that probably begins early in adolescence or preadolescence. As outlined in Figure 14, the first step in the process is thinking about smoking cigarettes, and as children move into their teen years, a substantial fraction change from believing that they

will never use cigarettes to considering experimentation with smoking. The omnipresent images from tobacco advertising of the smoker as a confident, attractive, and secure individual (Tye, 1985), as well as examples of adult and older sibling smokers, are powerful inducements for children to perceive smoking as an entry into adulthood. Counteradvertising that creates a negative image of the smoker—for example, the smoker as inadequate and less mature—can be used in an effort to offset these influences.

The transition from thinking about smoking to having the first cigarette may not lead irreversibly to adult smoking, but clearly it is an important milestone in that passage. The widespread availability of cigarettes to teenagers and, particularly, the promotional distribution of free cigarettes, many of which are given to teens either directly or indirectly, clearly facilitate the teenager's experimentation with smoking. In contrast, programs that immunize teens through assertiveness training and modeling of refusal responses can be used to block this stage of initiation (Glynn, 1989).

The change from occasional experimentation with cigarettes to regular cigarette use is critical, because with regular use the adolescent develops a body of experience in which smoking is psychologically and sociologically useful. Clearly, the ability to purchase cigarettes easily, the social rewards, and peer acceptance of the teen's smoking behavior are critical to the development of regular use. However, the images created by tobacco advertising may also play an important role. The advertising images of the smoker as a confident, physically and sexually attractive, successful, and secure adult may resonate strongly in the adolescent who desperately wants to adopt and project those images. The ability to superimpose the advertising image on his or her own inadequate self-image makes the adolescent feel better, at least temporarily, and teenagers thus begin to develop a body of experience with the use of the cigarette to adjust their internal mood. Those adolescents without external validation of their self-worth have the greatest need to adjust their self-image and thus may be more likely to use cigarettes to do so.

School-based health education programs and programs that raise adolescents' self-esteem, as well as efforts to restrict advertising and promotional activities, are aimed at altering the transition to regular smoking (Glynn, 1989). Raising the cost of cigarettes, because adolescents have limited disposable income, and increasing the social unacceptability of smoking, even among teens, are further barriers to the transition.

Progressing from regular use to dependent use requires that the utility of tobacco use persist after the pervasive anxieties of

adolescence dissipate. For utility of the cigarette to continue, cigarette smoking has to be allowed in those situations when the smoker wants to use the cigarette. For smokers to learn to use cigarettes to handle stress at work, they must be allowed to smoke at the time when those stresses occur. If smoking is banned in the worksite, not only do smokers learn to not use the cigarette to cope with those stresses, but also they are obligated to develop alternative mechanisms to handle stress, and those mechanisms may be substituted for smoking in other settings as well.

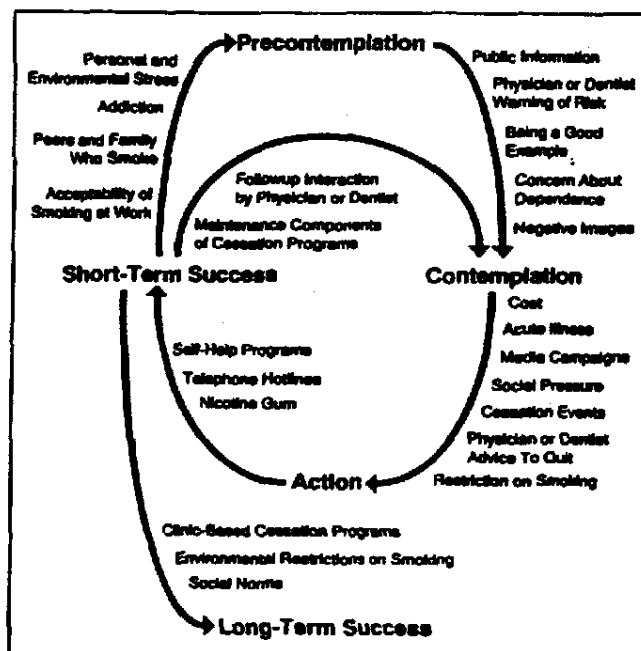
The socialization of an adolescent into the workforce may include powerful social reinforcement for smoking behavior, particularly in the military environment. Older role models and social norms that promote smoking can increase the utility of smoking for the young smoker and facilitate the transition to dependency. Conversely, the elimination of smoking from the worksite and the development of workplace norms that discourage smoking may weaken the dependence on tobacco and increase the development of other coping skills.

#### Affecting the Cessation Process

The majority of smokers want to quit, and this desire culminates in attempts to quit by approximately one-third of smokers each year (Pierce and Hatzidreou, 1989). The cyclical pattern of not thinking about quitting (precontemplation), thinking about quitting (contemplation), and attempting to quit—with success or failure—generates a new set of nonsmokers each time a group of smokers passes through the cycle (Prochaska and DiClemente, 1986). One formulation of the process of cessation, and the points at which specific smoking control interventions can influence the stages of cessation, is presented in Figure 15. The diagram is a simplification of the effects of smoking control efforts, but it gives an overview of the possible interactions in a comprehensive control program.

Many environmental influences and programs for controlling tobacco use are intended to influence smokers at different points in this cycle. Public information campaigns that present the risks associated with smoking are intended to move smokers from the precontemplation to the contemplation stage, as is personalizing of the risk of smoking through physicians' warnings. However, there are other reasons why smokers think about quitting, including concerns about addiction to cigarettes and interest in being a good example. Recently the negative image of the smoker and the social unacceptability of smoking have also provided strong reasons why smokers think about quitting. Individual programs to control tobacco use can aim and have been aimed at altering the frequency and intensity with which these motivational issues are presented to the smoker.

Figure 15  
Process of cessation



The move from thinking about quitting to making an attempt to quit is often triggered by a variety of environmental stimuli. The data from California presented above suggest that an increase in the cost of cigarettes can be a powerful trigger for cessation attempts.

A physician's or dentist's advice to quit smoking, particularly when it is related to an acute illness, also is a powerful trigger for cessation, with up to half of the patients who are advised to quit making a cessation effort (US DHHS, in press). Media campaigns, especially when coupled with cessation events such as the Great American Smokeout, also can trigger cessation attempts by large numbers of smokers (Gunby, 1984). Changes in workplace rules to restrict smoking on the job have been associated with attempts to quit by a substantial number of workers.

Triggering cessation efforts, whether or not they succeed, is an important strategy because each round of cessation activity results in a few more nonsmokers. The large proportion of smokers who attempt to quit each year is a testament to the success of those components of the control effort that are designed to move smokers from precontemplation to contemplation and from contemplation to action. The major gap in current control efforts is in converting cessation attempts into long-term successes.

Self-help programs, telephone hotlines, and nicotine gum are all useful enhancers of short-term success in smoking cessation, and clinic-based programs have a substantial benefit for long-term cessation for those who can be recruited to participate (Schwartz, 1987). However, the major barriers to long-term success remain difficult to alter and, with the exception of addiction, are largely in the smoker's environment. They include social norms and workplace rules that promote smoking and facilitate relapse, the continued smoking behavior of peers and family members, and unusual episodes of stress that lead the smoker to fall back on old coping strategies, including smoking. Long-term success remains the most elusive component of a comprehensive strategy to control tobacco use; however, the prospect of continued changes in social norms and tighter restrictions on where smokers can smoke offers hope that even this component may show improvement in the future.

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## Chapter 2

# Evolution of Smoking Control Strategies

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## Chapter 2

# Evolution of Smoking Control Strategies

### INTRODUCTION

Evidence linking cigarette smoking with cancer began to accumulate in the 1930's and rapidly increased in the late 1940's and early 1950's. Four retrospective studies of the smoking habits of lung cancer patients and controls were published in 1950 (Doll and Hill, Levin et al., Schrek et al., Wynder and Graham), and each noted a consistent, statistically significant association between smoking and cancer of the lung.

Between 1954 and 1958, Hammond and Horn reported the findings of their large-scale prospective study of 187,783 U.S. males that showed significantly higher overall death rates for smokers than for nonsmokers. In the same years, a prospective mortality study of 40,000 British physicians provided independent demonstration of the relationship between cigarette smoking and disease (Doll and Hill, 1954 and 1956). The strength and consistency of these results, combined with evidence from laboratory and autopsy studies, led a national scientific study group to conclude that there was a causal relationship between smoking and lung cancer (Study Group on Smoking and Health, 1957).

In the following sections, this chapter describes how strategies for reducing the prevalence of smoking in the United States have evolved from the simplest approaches to information dissemination, through clinics and self-help techniques, to contemporary, comprehensive approaches to smoking control—employing multiple strategies drawn from every relevant sector of our environment. The discussion is organized under topic headings, as follows:

- Information and Education Campaigns
- Cessation Program Strategies
- Prevention Strategies
- A Comprehensive Approach to Smoking Control
- Conclusions.

### INFORMATION AND EDUCATION CAMPAIGNS

In the early 1950's, a few popular publications transmitted the new scientific findings about smoking to the lay public. There were several reports in *Reader's Digest* (Lieb, 1953; Miller and Monahan, 1954; Norr, 1952; Riis, 1950) and in *Consumer Reports* (1953, 1954, and 1955) that informed the public of the health hazards of smoking. By the mid-1960's, information

and education campaigns—both private-sector and Government-funded—became more intensive.

Recognition of the health hazards of smoking led to organized efforts to inform smokers about the risks of tobacco use, with the expectation that large numbers of smokers would be convinced of the need to quit (Flay, 1987a). Media-based messages and educational campaigns were the earliest smoking control activities.

The 1964 Surgeon General's Report on Smoking and Health accelerated the Government and the voluntary health organizations' efforts to educate and inform the public about the hazards of smoking (US DHEW, 1964). The attention generated by the legislative requirement for an annual Surgeon General's Report, and the media coverage surrounding its release, became one of the primary ways that the Federal Government informed the public about the health consequences of tobacco use. Since 1966, the Government has required a health warning on all cigarette advertising and on every package of cigarettes sold in the United States.

The National Clearinghouse for Smoking and Health and national voluntary health organizations were also among the early sponsors of newspaper advertisements against smoking and of antismoking campaigns on television and radio. The American Cancer Society, the American Lung Association, and the American Heart Association used mass distributions of pamphlets, posters, and films to detail the risks of tobacco use. The voluntary health agencies also developed antismoking public service announcements.

Interagency councils on smoking and health and Federal, state, and local health departments participated in the anti-smoking campaign. Educational materials and programs were introduced in local communities, schools, hospitals, and businesses. Medical, dental, and public health groups joined in the campaign to curtail smoking. As a result of the educational campaigns precipitated by the accumulation of scientific evidence, temporary declines in total per capita consumption of cigarettes occurred during 1953 to 1954, 1964, and 1968 to 1970. These declines coincided with periods of increased publicity about the health hazards of cigarette smoking (US DHEW, 1979).

The statutory ban on broadcast cigarette advertisements virtually eliminated antismoking messages, as well, from prime viewing hours after 1971. Some studies (Schneider et al., 1981; Warner, 1977) attribute the subsequent increase in cigarette consumption in 1972 and 1973 to the discontinuation of the antismoking commercials.

The tobacco industry responded to these public information campaigns by denying that cigarette smoking caused disease, and industry spokespeople used the media to dispute the link between smoking and disease. In addition, they adopted a strategy that included attacking weaknesses in individual scientific studies—as a method of discrediting the large and growing body of information that was establishing the risks of smoking—and confusing smokers about the level of scientific certainty about the causal relationship and the importance of quitting.

At the same time, cigarette manufacturers were developing and marketing new filter cigarettes to ease (and take marketing advantage of) smokers' growing health concerns. Filters were advertised as a technological improvement to remove the harmful elements of smoke (US DHHS, 1989). In 1952, when reports linking cigarettes to lung cancer first appeared, 1 percent of all cigarettes were filter-tipped (US DHHS, 1989). By 1954, the percentage of filtered cigarettes had increased to 9 percent. The filter-tip market share rose by at least 9 percentage points during each of the next 3 years, reaching 38 percent by 1957. By the time the 1964 Surgeon General's Report was published, the market share of filter cigarettes had reached 61 percent.

During the 1970's, the industry adopted a second marketing strategy in response to the increasing awareness and concerns of smokers. The advertising campaigns of this period encouraged smokers to switch to low-tar and low-nicotine cigarettes. Smokers' acceptance of low-tar and low-nicotine cigarettes accelerated rapidly.

At least 3 million people succeeded in quitting smoking in 1954 (Horn, 1978). In subsequent years, between 1 million and 3 million people gave up smoking each year (Horn, 1978); however, many more smokers tried to quit but did not succeed. Many smokers were dismayed to discover that long-term success was elusive.

Increasing awareness of the problems created by tobacco use, and the difficulties associated with achieving and maintaining cessation, led to the gradual adoption of more comprehensive and intensive approaches to the reduction of tobacco use.

Smoking cessation clinics were developed to address the difficulties smokers had in quitting on their own. Early clinics combined medication with educational lectures, pamphlets, and physician counseling over a 10-day course. During the 1960's, more than 100 smoking cessation programs were reported in the United States, Canada, 11 European countries,

#### CESSATION PROGRAM STRATEGIES

and Australia (Schwartz, 1969). During the 1970's, about 300 cessation methods were reported in the literature (Pechacek, 1979; Schwartz, 1977 and 1987).

A listing of cessation programs reported over the past four decades reveals a change in the emphasis of cessation methods (Schwartz, 1987). In the late 1950's, methods were primarily educational or medication-based (Schwartz, 1969). The leading programs in the 1960's and 1970's were 5-day plans, group discussion, and conditioning-based procedures such as rapid smoking and satiation (Schwartz and Rider, 1978). Other popular treatments in the 1970's were self-help in the form of "how-to-quit" manuals, books, filters, and over-the-counter drug products; group therapy; professional counseling; hypnosis; and cognitive-based, self-management approaches. The approaches that were emphasized in the 1980's (Schwartz, 1987) include self-help, multiple-component programs, hypnosis, acupuncture, physician advice and counseling, nicotine chewing gum, skills training and relapse prevention, and mass media and community programs.

Most of the early smoking cessation clinic approaches focused on changing smokers to enable them to alter their behavior and to resist environmental influences to smoke. The limited success of these early approaches, in terms of both smoker recruitment and long-term cessation, has led to a greater appreciation of the role of environmental influences on smoking behavior. A major emphasis of efforts to control tobacco use has been on altering the smoker's environment in ways that will promote cessation and facilitate long-term abstinence. Cessation clinic approaches are one component of the current comprehensive approach to smoking control, and they have incorporated awareness and manipulation of environmental factors in their program content.

Following the lead of clinic programs in Europe, the National Interagency Council on Smoking and Health assisted local interagency councils in the development of smoking cessation activities. The National Council sponsored a series of workshops on smoking cessation and, with the American Cancer Society, initiated the First World Conference on Smoking and Health in 1967. The U.S. National Clearinghouse for Smoking and Health sponsored community antismoking campaigns in San Diego, California, and Syracuse, New York.

Local units of the cancer, lung, and heart associations also initiated clinic programs. The American Cancer Society developed a manual for withdrawal clinics based on a work conference attended by scientists who had experience with cessation methods. The Seventh-Day Adventist Church offered a highly

structured, intensive 5-day plan in many localities. Community health agencies, public health departments, hospitals, sanitariums, and group health plans also conducted cessation programs (Schwartz and Rider, 1978). The evolution of smoking cessation theories and programs through a variety of provider types is discussed below.

#### Health Volunteers' Efforts

Clinic methods generally employed either an educational approach or a support-group format. The American Cancer Society "Helping Smokers Quit" clinics were an educational approach that was standardized throughout the United States via use of selected guides, printed materials, and trigger films presented by extensively trained volunteers (Schwartz and Rider, 1978). Groups met for eight 2-hour sessions, generally twice a week. Interaction of group members facilitated personal growth and helped to reinforce abstinence from smoking. The clinic had three phases: self-appraisal and insight development, practicing abstinence under controlled conditions, and maintaining abstinence. Volunteer clinic leaders were recruited from graduates who had quit smoking. American Cancer Society clinics spread to the organization's 58 divisions and 3,100 local units.

In the 1980's, the cancer society revised its clinic program. The revamped program, FreshStart, consists of four 1-hour, small-group sessions designed to help participants understand why people smoke, handle withdrawal symptoms, practice stress management, and assimilate tips to help them refrain from smoking.

Local units of the American Lung Association sponsored a variety of cessation clinics. The American Lung Association provided clinic guidelines to local units, but individual chapters designed their own programs. In the 1980's, the lung association produced excellent quitting and maintenance manuals that emphasized self-help. The lung association also developed a clinic program based on education and principles of behavior modification. The clinic used the *Freedom from Smoking* manuals in a seven-session format, a method that offered a systematic approach for reducing the stress of quitting. The American Lung Association initiated a national program to train staff members to run clinics, manage publicity, and recruit clinic leaders. The promotion's emphasis was to interest major corporations in sponsoring programs that used the self-help and clinic modes.

Many schools offered smoking prevention programs and cessation classes for high school students and adults; colleges and universities also provided quit courses (Schwartz and Rider, 1978). Hospitals, health departments, and physicians sponsored educational sessions for smoking cessation, generally

#### Withdrawal Clinics

## Five-Day Plan

consisting of lectures, films, literature, instructions on how to quit, diet information, and responses to questions. The *Smoker's Self-Testing Kit* (US DHEW, 1969) was used often, and each person was paired with a "buddy."

In 1960, the Seventh-Day Adventist Church launched the Five-Day Plan To Quit Smoking (McFarland et al., 1964), which consisted of five consecutive sessions of 90 to 120 minutes each. There were no followup sessions in the first several years of the program, but maintenance meetings were added later. Groups varied in size from 15 people to several hundred.

Usually, at the first session, a film showing surgery on a cancerous lung was presented. Immediate smoking cessation was prescribed, and participants were temporarily prohibited from drinking coffee, tea, cola, and alcohol. Physical fitness, exercise, balanced diets, increased fluid intake, warm baths, hot and cold showers, body rubs, deep breathing, and a "buddy system" were encouraged to offset the potential difficulties of withdrawal from nicotine. The physiological effects of smoking were discussed in these sessions, and lung specimens were displayed. Clergymen, psychologists, or physicians presented spiritual, mental, or medical lectures and conducted counseling.

The Five-Day Plan was copied widely, in modified form, by professionals and laypersons. The main aspects that other programs copied were the 5-day format and the buddy system.

## Commercial Programs

Proprietary groups began offering cessation programs in the late 1960's (Schwartz and Rider, 1978; Schwartz, 1987). Smoke Watchers, formed in 1968, offered slow withdrawal and weekly goals. Smokers attended open group meetings, with new members joining and graduates and dropouts leaving the group.

SmokEnders, started in 1969, ran chapters directly and granted some franchises. SmokEnders did not build centers; instead, community facilities were used (e.g., churches, schools, and hotels). In terms of acceptance and marketing, SmokEnders has been the most successful commercial stop-smoking program. SmokEnders is a highly structured, systematic technique that emphasizes positive reinforcement and changing attitudes. The original format consisted of eight weekly meetings with a "cut-off day" after the fifth meeting (Schwartz, 1987). The last three meetings were intended as reinforcement, and all moderators were graduates of the program. The course was subsequently reduced to 6 weeks, with the quit day after the fourth session.

Schick Centers for the Control of Smoking started in 1971. The company operated all centers and invested in building

facilities and television promotion. When the public did not respond, Schick closed its Eastern U.S. units and concentrated in five states. The Schick method consists of 5 days of aversive conditioning (low-grade shocks and smoke satiation), followed by 6 weeks of predominately educational group meetings (Schwartz, 1987).

Two other national commercial organizations with similar programs were formed in the 1980's. SmokeLess and Smoke Stoppers license their treatment programs mainly to hospitals and businesses. These organizations conduct training and provide materials to licensees. The SmokeLess and Smoke Stoppers systems are educational, intensive, and highly structured. Attractive pamphlets guide the smoker through the program, with methods that include stress management, positive rewards and reinforcements, food management, and negative smoking practices. Four classes designed to enable smokers to quit are held the first week, followed by 2 or 3 weeks of maintenance sessions.

A review of the 1967 through 1977 telephone yellow pages from more than 200 U.S. cities revealed that commercial stop-smoking programs were available in most major cities and many smaller communities (Schwartz and Rider, 1978). A similar review of the 47 largest U.S. cities for the years 1984 and 1985 showed an increase in such listings from 112 to 385 (Schwartz, 1987). What was striking about the differences between these two periods was that commercial programs, which made up about one-half of the listings in the first survey, accounted for only one-fifth in the later survey. Hypnosis programs made up 17 percent of the listings in the earlier survey but almost one-third in the second survey. The proportion of physician and acupuncture listings also increased in the second survey.

## Medication

Chemical agents have been offered as smoking deterrents since before 1900. Early deterrents consisted of herbs, spices, and mouthwashes that produced a disagreeable taste for the smoker (Schwartz, 1969). Other products aimed at diminishing the sensory drives or creating a dry mouth (US DHEW, 1964). In 1982, a Food and Drug Administration panel concluded that drug products such as chewing gum, mouth sprays, and tablets containing silver acetate were not effective as aids to smoking cessation (Food and Drug Administration, 1982).

A variety of drug types, including anticholinergics, sedatives, tranquilizers, sympathomimetics, and anticonvulsants, have been used to reduce the psychological and physiological symptoms of withdrawal. Prior to the introduction of nicotine chewing gum, Jarvik and Gritz (1977) reviewed the literature and concluded that drug therapy was not particularly useful in curing the smoking habit.

## Nicotine Gum

Nicotine polacrilex (Nicorette) is a prescription drug in the form of chewing gum that contains 2 mg of nicotine bound by an ion exchange resin that allows for a slow release of nicotine when chewed. Patients are advised to use the gum for at least 3 months. However, some smokers need to use the gum for 6 months or more to alleviate their urge to smoke.

In 1984, Lakeside Pharmaceuticals, a division of Merrell Dow, undertook a massive promotional campaign after the Food and Drug Administration approved its nicotine gum. The result of this campaign was that nicotine polacrilex became one of the fastest selling prescriptions ever introduced. Sales were \$42 million in 1984 and grew to \$60 million in 1987 (US DHHS, 1989).

The availability of nicotine gum has encouraged physicians and dentists to advise their patients to quit smoking because now these providers have some assistance to offer the patient who wants to quit. There are indications, though, that most physicians do not provide proper instructions on the use of the gum. Schneider et al. (1984) and Sachs (1986) have cautioned that the patient must understand the limitations of the prescription and be instructed carefully on its use. Practitioners who have experience in the use of nicotine gum, and who provide instructions and additional advice and counseling, have achieved good results (Fagerstrom, 1982; Hall et al., 1987; Killen et al., 1984; US DHHS, 1988). In the absence of counseling or therapy, success rates are low (Schwartz, 1987; US DHHS, 1988).

## Other Drug Treatments

More recent approaches to drug therapy include citric acid spray, nasal nicotine solution (Jarvis, 1986), nicotine vapor (Russell et al., 1987), nicotine-containing skin patches (Rose et al., 1985), and clonidine, a drug used to treat hypertension. Clonidine has been found to reduce the urge to smoke, and researchers have speculated that it may relieve nicotine withdrawal symptoms (Glassman et al., 1988). A clonidine transdermal patch is currently being tested as an aid to smoking cessation (US DHHS, 1989).

Mecamylamine has been suggested as an antagonist to block the nicotine-mediated reinforcing consequences of cigarette smoking (Henningfield et al., 1982; Pomerleau et al., 1987). Mecamylamine is not meant as a cessation aid; rather, it is used to maintain abstinence. In one clinical trial, however, heavy smokers were treated with mecamylamine and showed short-term positive cessation effects (Tennant et al., 1984).

## Behavior Modification

Behavior modification entails two divergent approaches to behavior change. One approach uses punishment and the other uses positive reinforcement—including self-management

## Aversive Procedures

procedures. For a detailed overview of behavioral methods, the reader is referred to reviews by Best and Bloch (1979), Glasgow (1986), Hall and Hall (1985), Lando (1981), Lichtenstein and Brown (1983), Pechacek (1979), Pechacek and McAllister (1980), Schwartz (1969 and 1987), and Schwartz and Rider (1978).

Aversion therapy for smoking developed in the 1960's and included electric shock, desensitization training, breath-holding, overexposure to stale smoke, and covert sensitization. The use of electric shock as a punishing stimulus to eliminate smoking behavior has had limited success. The most promising techniques use some form of smoke aversion.

**Satiation.** Wilde (1964) attempted to induce a dislike for the taste of cigarettes by combining satiation with aversive, avoidance, and instrumental conditioning. This procedure showed only limited success. Subjects were required to increase the number of cigarettes they smoked and the rate at which they smoked. Early reports by Resnick (1968) claimed positive results for satiation, but other investigators were not able to replicate that success. Satiation has generally been combined with other procedures. Lando (1977) and Best et al. (1978) designed successful multicomponent programs that included satiation.

**Rapid smoking.** Lublin and Joslyn (1968) combined hot, smoky air with rapid smoking and reported fair results. Their study was criticized for invalid methodology, but it set off a series of experiments by Lichtenstein and his colleagues, which subsequently produced impressive results for rapid smoking. Their procedure required the subject to inhale from a cigarette once every 6 seconds for the duration of the cigarette or until nausea developed.

In the early trials, Lichtenstein's group used warm, smoky air along with rapid smoking but dropped the warm air when they found it did not contribute to effectiveness (Lichtenstein and Brown, 1983). There was some concern that rapid smoking created a risk to the cardiopulmonary system, but serious consequences have not been evident. Nevertheless, subjects should be screened and monitored closely during treatment. Rapid smoking has continued to be a popular treatment for smoking, and multiple-component treatments that include rapid smoking have shown good long-term success (Hall et al., 1984; Pechacek, 1979).

**Covert sensitization.** The objective of covert sensitization is to produce avoidance behavior through use of the subject's imagination. Both the behavior to be modified and the noxious stimulus are imagined. This procedure showed promise in early case studies, but controlled trials failed to replicate the early success (Pechacek, 1979; Schwartz, 1987).

Self-Management  
Techniques

*Other smoke aversion procedures.* Other smoke aversion methods include the use of smoky air, chain smoking, regular-paced aversive smoking, and smoke-holding. Regular-paced aversive smoking may be performed in a variety of ways. Generally, the procedure is done at home. Subjects smoke at their usual rate while focusing on the negative features of cigarettes, such as the irritation in the mouth and throat, coughing, and the accumulation of smoke. When regular-paced smoking is the only treatment, the procedure yields low success rates, but when it is used with a treatment program, the quit rates are much improved (Schwartz, 1987).

Smoke-holding consists of retaining the smoke in the mouth for 30 seconds or until feelings of discomfort reduce the desire to smoke. This appears to be a safe procedure, but there are not enough data for assessing its efficacy in smoking cessation.

Strategies for quitting smoking through self-management encompass a variety of techniques, some of which are employed with aversive methods. These techniques generally are initiated and directed by leaders or therapists. Predominant self-management methods are those based on concepts of self-monitoring, nicotine fading, stimulus control, contingency contracting, systematic desensitization, and restricted environmental stimulation therapy. Self-management techniques also have been employed in multiple-component programs, discussed below.

*Self-monitoring.* Program requirements for self-monitoring have differed greatly—from having the participants count the number of cigarettes smoked in just 1 day to having them keep elaborate records for 1 or more weeks, noting the time, place, activity, and mood when smoking each cigarette and somehow rating or ranking the perceived need for each. McFall (1970) demonstrated that, when people begin paying close attention to their smoking behavior, it is likely to change even though no change may be intended or desired. Glasgow (1986) commented that self-monitoring can be useful, provided that monitoring assignments are not overly complex, are varied, and are not continuously required throughout a lengthy program.

*Nicotine fading.* Slowly reducing nicotine intake by changing to brands with lower nicotine content (brand fading) or cutting down the number of cigarettes smoked (tapering) are ways of gradually withdrawing from nicotine. Smoke Watchers, the first national commercial program, based its method on gradual withdrawal and weekly goals assigned by the group leader (Schwartz and Rider, 1978). Although Smoke Watchers had some success with tapering, the evidence for gradual

reduction in numbers is not very positive. As the number of cigarettes is reduced, each remaining cigarette can become more reinforcing. However, with nicotine fading, individuals can continue to smoke the same number of cigarettes while reducing their nicotine intake. Some investigators have shown good results with brand fading. Several commercial filters are marketed with the aim of progressively reducing the tar and nicotine content of a cigarette as a way of helping smokers to break the habit.

Nicotine fading by changing brands was introduced by Foxx and Brown (1979), who advocated nicotine content reductions of 30, 60, and 90 percent over a 3-week period. Some investigators use a different schedule, and most include other procedures in the treatment. The many trials conducted in the 1980's attest to the level of interest in nicotine fading. Brown and Lichtenstein (1980) combined nicotine fading with relapse training, whereas Lando and McGovern (1985) used it with smoke-holding.

*Stimulus control.* In the mid-1960's a number of behavioral investigators used stimulus control techniques as a treatment for smoking (Schwartz, 1969). Stimulus control is intended to eliminate undesirable behaviors by altering the situations in which the maladaptive response occurs. Either the situation can be altered or the individual's response to the situation can be altered. Generally, smoking is associated with a variety of specific environments and internal events, and these associations trigger the smoking response.

One strategy seeks to increase the stimulus interval through use of a cueing device (e.g., pocket timer or signal device). Once the new smoking cue is well established, it is gradually faded out via increased time intervals.

Another type of stimulus control is hierarchical reduction. Subjects are asked to monitor their smoking activity carefully and identify situations in which they are more likely or less likely to be smoking. The subject then eliminates smoking in a cumulative and progressive fashion, from the easiest situation to the hardest. Limiting the circumstances in which smoking is allowed is another strategy. The procedure permits smoking only in a deprived setting, one devoid of all possible distractions and accompanying reinforcers.

The reported studies do not provide evidence to support stimulus control as an effective cessation procedure (Schwartz, 1987). Keeping a detailed account of the subject's feelings and activities related to smoking provides insight to the habit, which can assist the smoker in quitting as long as the treatment also includes other features, such as counseling, maintenance, and relapse prevention.



**Contingency contracting.** The purpose of contingency contracting is to enhance the smoker's motivation through commitment. Two forms of these contracts are monetary deposits and social contracts with peers. Early studies (Elliott and Tighe, 1968; Winett, 1973) demonstrated that refunding portions of deposits to subjects for continued abstinence influenced long-term cessation.

Signing formal contracts with subjects is one program aspect that achieved good success rates (Lando, 1977). Subjects pledged to forfeit money for every cigarette smoked and agreed to undergo an aversive booster treatment after any smoking. Stitzer and Bigelow (1982) offered contingency payments to subjects who reduced their smoking and thereby reduced their carbon monoxide levels by 50 percent. Including contingency contracting as one aspect of a multicomponent program may contribute to success, but it has limited application as a primary treatment.

**Systematic desensitization and relaxation.** Desensitization was intended to strengthen responses that are incompatible with smoking. It was hypothesized that smoking behavior is frequently cued by anxiety, and if the prior and proximal stimuli leading to smoking were desensitized, then smoking would diminish. Other investigators suggested that subjects could be conditioned to relax as an alternative to smoking. Still others believed that reducing the stress generated by quitting would help to create positive results.

Many investigators have incorporated desensitization and relaxation training into their programs. However, controlled studies do not support desensitization as a treatment for smoking. Although relaxation seems to make sense as a helpful procedure, nicotine has primarily stimulating effects, and the smoker seeking stimulation may not find a satisfactory replacement in relaxation.

**Restricted environmental stimulation therapy.** The form of therapy known as restricted environmental stimulation derives its rationale from evidence that a period of sensory deprivation increases persuadability and responsiveness to external cues (Suedfeld and Best, 1977; Suedfeld, 1984). Although several investigators have demonstrated success with this method, the need to keep a subject in a soundproof chamber and provide a monitor has discouraged use of this procedure.

The large number of smokers who attempt to quit each year, coupled with the reluctance of smokers to participate in cessation clinic promotions, has led to the production of a variety of aids to assist smokers in their self-directed efforts to quit smoking (Schwartz and Rider, 1978; Schwartz, 1987). The earliest materials were stop-smoking books, quit kits, and

filters; later, audiotapes, correspondence courses, and smokeless cigarettes were marketed. Videocassettes and computer programs have become available more recently (Schwartz, 1987).

The *Smoker's Self-Testing Kit* was used by several million smokers (Horn, 1972; US DHEW, 1969). It helped smokers gain insight about their habit by providing an understanding of how one feels about cigarettes, how one uses them, and the factors that inhibit or enhance the effort to quit.

Several dozen quit-smoking books and guides have been produced (Schwartz, 1987). In 1977, the American Cancer Society developed the *I Quit Kit*, which consisted of portions of the *Smoker's Self-Testing Kit*, instructions for quitting, and tips on how to stay away from smoking. The Federal Office on Smoking and Health provided smoking cessation pamphlets, and NCI designed the *Helping Smokers Quit Kit*, which contained materials for the smoker and the physician.

The American Lung Association produced two manuals for people who aim to quit on their own: *Freedom From Smoking in 20 Days*, a 64-page cessation guide, and *A Lifetime of Freedom From Smoking*, a 28-page maintenance booklet. The cessation guide includes part of the *Smoker's Self-Testing Kit*, identifies smoking triggers, and offers information about controlling weight, handling smoking situations, and performing deep breathing and relaxation exercises. The maintenance booklet supports ex-smokers after they quit. These are well-designed manuals that have proven to be very popular (Lando et al., 1990).

"How-to-quit-smoking" books have been written primarily by ex-smokers and psychologists. Glasgow et al. (1981) compared the cancer society's *I Quit Kit* to two behavioral self-help books, one by Pomerleau and Pomerleau (1977) and the other by Danahey and Lichtenstein (1978). Under self-help conditions, the American Cancer Society manual was rated best. Glasgow (1986) postulated that subjects using relatively complex self-administered behavioral programs would have great difficulty in following them. When a therapist led the treatment using the same materials, the behavioral books came out better than the cancer society's manual.

An early aid to quitting, still marketed today, is a filter that reduces the nicotine level in cigarette smoke and permits the smoker to be weaned from the chemical addiction (Schwartz, 1987). The device, marketed by Teledyne Water Pik, consists of four reusable filters that reduce the nicotine content of inhaled smoke progressively. The smoker is supposed to use each filter for 2 weeks. As with any cessation method that does not attack the psychological addiction to smoking, evaluations of filter use have shown little long-term success.

## Multiple-Component Programs

A new filter system is currently being marketed by Vipont Pharmaceuticals; it consists of three nicotine-fading filters to be used over 21 days. To address psychological addiction, the system includes a deck of cards to help in overcoming dependence and provide coping tips to be used after quitting.

Other self-help cessation aids include quitting by mail, taped telephone messages, cigarette holders and dispensers, videotapes, and several types of computer-based methods.

Many clinic approaches combine several procedures in their methods. Almost all multiple treatments include self-control procedures (e.g., nicotine fading, abstinence training, relaxation, or stimulus control). Many multicomponent programs include smoke aversion as a way of breaking the habit and self-control to maintain nonsmoking (Best et al., 1978; Lando, 1977). Some of the very best results have been achieved with multiple-component programs (Hall, 1980; Killen, 1984; Lando, 1977).

Lando (1977) has used satiation, contractual management, and group support for his multicomponent program; and Pomerleau et al. (1978) provided a multicomponent treatment consisting of stimulus control, covert conditioning, contingency management, relaxation, and use of pocket timers.

Multicomponent programs have achieved the highest quit rates at 1-year followups (Schwartz, 1987). For example, Lando (1977) reported 76 percent success at 6 months after combining satiation, contractual management, and group support; and Hall et al. (1984) achieved a 52 percent quit rate at 1 year by using rapid smoking and relapse prevention. On the other hand, Beaver et al. (1981) scored only 6 percent success at 6 months with the combination of nicotine fading and anxiety management training, which suggests that not all multicomponent programs are highly successful.

Lichtenstein and Brown (1983) and Glasgow (1986) have cautioned that more is not always better. Too many procedures may confuse subjects and make it difficult to provide an integrated treatment. Multicomponent treatments remain attractive because they deal with the multiple factors involved in smoking, as well as the considerable differences among smokers (Lichtenstein and Brown, 1983).

Once smokers have quit, there are myriad environmental, social, and psychological forces that act to influence them to return to smoking (Schwartz and Rider, 1978). During the first 4 months after treatment, many successful quitters become recidivists, and during the next 8 months, other ex-smokers return to smoking. Some people return to smoking after a year or more of abstinence (Schwartz, 1987). During the 1980's,

PREVENTION STRATEGIES  
Relapse Prevention

investigators studying relapse identified high-risk situations. Multicomponent programs included training in cognitive behavioral skills to help quitters develop strategies for identifying and coping with high-risk situations.

## Relapse Situations

Marlatt and Gordon (1980) found that the majority of relapse situations involved social pressure to smoke. They indicated that causes for relapse fell into three categories: social pressures, coping with negative emotional states, and coping with interpersonal conflict. They concluded that effective maintenance requires that the smoker be taught coping responses to relapse stimuli.

Shiffman (1984) interviewed people who called a relapse counseling hotline and found that most of their relapse crises were associated with negative feelings (e.g., anxiety, anger, depression). One-third of the crises however, were linked to positive emotional states and frequently involved other smokers. Ex-smokers who used coping responses more often were able to refrain from smoking.

## Maintenance Strategies

Lichtenstein (1979) identified three maintenance strategies: social support, coping skills, and cognitive restructuring. Social support is based on the theory that a group of close companions can provide support or influence to help the ex-smoker sustain the motivation to continue abstaining. Coping skills are required to help the new nonsmoker deal with withdrawal symptoms, develop substitute responses that will replace smoking, and learn to recognize and modify cues to smoke (Lichtenstein, 1979). Cognitive restructuring involves changing attitudes and self-perceptions related to smoking.

Support may come also from a support group or from the teaming of two or more clients as "buddies" to telephone each other and provide mutual support. Another support tactic is continued contact between the program and the client via telephone, letters, and personal meetings. Other support techniques include contingency contracting, bonuses, self-rewards, and positive feedback.

Effective treatment procedures include cognitive recognition and behavioral training in coping with abstinence violation (defined as a slip by a quitter that leads to backsliding) and self-efficacy factors (Marlatt and Gordon, 1980). Investigators caution that effective maintenance calls for minimizing the impact of slips as a way of coping with abstinence violation.

## Skills Training

Coping strategies can be used both to prevent high-risk situations and to respond to them (US DHHS, 1988). Both knowledge and performance of relapse prevention skills are needed to maintain change. Lichtenstein and Brown (1983) cite a number of studies that yielded favorable results from use of coping skills or self-management training.

Schwartz (1987) found differences between some programs that offered self-management procedures and those that offered coping skills, relapse management training, or abstinence training. For example, Hall et al. (1984) combined rapid smoking with a relapse prevention program that included both behavioral and cognitive components. The coping skills addressed withdrawal symptoms and situational factors related to relapse (skills training for high-risk situations). This program attempted to individualize techniques. Relaxation was presented as a means of coping with the anger and anxiety that often precipitate a relapse. Four relapse prevention sessions were devoted to skills training, and subjects role-played alternative responses to high-risk situations.

Another example is the relapse prevention program devised by Brown and Lichtenstein (1980), which was based on strategies suggested by Marlatt and Gordon (1980). It consisted of five components: identification of high-risk situations, coping rehearsal, avoidance of the abstinence violation effect, lifestyle balance, and self-rewards.

Killen et al. (1984) studied the effects of skills training and nicotine gum, as separate methods and combined, in promoting abstinence after smoking cessation. Therapists demonstrated how strategies for selected target situations might be implemented. Participants then rehearsed coping responses specific to personal high-risk situations in front of the group. Therapists and group members provided corrective feedback after each rehearsal. Positive results were obtained in both skills training treatments.

Fortmann et al. (1988) studied self-directed relapse prevention in combination with nicotine polacrilex. Sixteen modules were written to provide self-instruction on avoidance of smoking in specific high-risk situations. All subjects perceived efficacy in coping with different high-risk situations. The study demonstrated that relapse prevention could be self-directed.

The recognition of the disease risks associated with tobacco use led to efforts to educate nonsmokers and to prevent adolescents and women from initiating tobacco use. These efforts evolved from preexisting campaigns to prevent women and children from smoking, programs that were based on concerns about the effects of smoking on morals and behavior (Troyer and Markle, 1983).

During the 1950's and 1960's, the major efforts directed at preventing initiation focused on adolescents. Unfortunately, little effort was directed at countering the advertising and promotional campaigns of the cigarette manufacturers that were directed to women, blacks, and Hispanics. The cigarette manufacturers' targeting may be largely responsible for the

#### Efforts To Prevent Initiation

current higher prevalence of cigarette smoking among young women than among young men, and the higher prevalence of smoking among black males than among white males (see Chapter 3).

The efforts directed at preventing adolescent initiation fell into two categories: school-based smoking prevention education and restrictions on the availability of cigarettes to adolescents. However, the perception that either or both of these approaches could eliminate use of tobacco by adolescents has led to disappointment and to recognition of these efforts as important components of a comprehensive smoking control strategy that requires the support and activity of other channels to be maximally effective.

We now have several comprehensive and effective curricula that deal with tobacco use (see Chapter 5); however, these curricula are not being used in the majority of U.S. school districts. Most states have mandates requiring that health education be taught in schools, but the task of implementing these mandates has often proven difficult or impossible. School health educators have come to realize that community perception of the importance of smoking as a problem, financing the costs of curricula and teacher training, and involvement of parents and the community in implementation of the curriculum are as important as the curriculum content for the success of these programs.

Similarly, the efforts to restrict adolescents' access to tobacco have been largely unsuccessful. Although 44 states have laws restricting the sale of cigarettes to adolescents, young people report little difficulty in obtaining cigarettes from stores and vending machines. Passage of legislation to limit tobacco sales to adolescents is ineffective in the absence of community support and enforcement.

#### COMPREHENSIVE APPROACH TO SMOKING CONTROL

The recognition that most adult smokers first become regular smokers as adolescents led to an early and continuing concern about the role of mass media, particularly through their advertising, in promoting tobacco use by adolescents. Some gains were made initially, most notably the effort to reduce the positive images of smoking in motion pictures, the ban of advertising on radio and television, and the elimination of sports personalities from cigarette ads. However, these early efforts did not prevent the continued targeting of adolescents, minorities, and women in the advertising and promotional efforts of the tobacco industry.

Perhaps the most visible failure to prevent use of tobacco by adolescents came in the late 1970's, with the reintroduction of smokeless tobacco products. These products were advertised on television with endorsement by sports personalities, and

adolescents were induced to use them through give-away programs. All of this activity occurred at a time when the scientific evidence establishing the carcinogenicity of these products had already been published. Once again, the failure in the effort to prevent initiation occurred secondary to the absence of a societal consensus and concern rather than an absence of knowledge or effective programs.

The recognition that efforts directed at educating the individual smoker and treating the individual to change smoking behavior had limited impact has led to an appreciation of the role of environmental influences in changing smoking behavior. Examples of more environment-related strategies that are believed to have had substantial impact on tobacco use include the nonsmokers' rights movement, which is changing the image of the smoker and restricting the number of locations where smoking is permitted, and the increase in taxes on cigarettes, which is creating a financial disincentive to smoke. These approaches reflect a growing understanding of environmental influences on the smoker, but even more important, they acknowledge the necessity of approaching the control of tobacco use through multiple channels and multiple programs. We now recognize that changes in the community's perception of smoking risks influence the adoption of school curricula and their effectiveness. By bringing all of the elements of society to bear on the problem, we hope to reduce initiation of smoking, provide persistent and inescapable messages to the smoker to quit, and create an environment where the smoker who is trying to quit has a better chance of success.

Six major subsystems, or sectors, are important in a comprehensive approach to smoking control: (1) the political sector, in which laws and policies are made; (2) the economic sector, which includes general taxation, workplace, business, and insurance policies concerning smoking control; (3) the educational sector, in which youth are educated about tobacco use; (4) the communication sector, through which information is disseminated to the general public; (5) the health care sector, in which health professionals play a crucial role in smoking control; and (6) the health voluntary sector, which provides many of the resources and coordination efforts directed to control of tobacco use.

Any system contains a number of established structures that can be mobilized to address smoking control; however, each structure must be examined for what the subsystem itself can do, for the opportunities it provides for multiple activities related to smoking control, and for opportunities for synergism with other sectors. In the following sections, the six subsystems named above are reviewed in this light.

## The Political Sector

The political sector is viewed as the major authority in determining what behavior is considered normative and what is deviant. This sector is especially important in defining ambiguous norms, because it is often the final arbiter in the interpretation of societal norms. In addition, societal norms are frequently codified into laws and/or policies; the political sector provides the mechanisms for such codification.

The political sector has already contributed enormously to tobacco restrictions. At the Federal level, tobacco use restrictions have been placed on transportation and in Federal Government workplaces (US DHHS, 1989). Through a number of initiatives, more than 40 states and the District of Columbia now have laws restricting smoking in at least one public place (US DHHS, 1989). Some states have comprehensive restrictions, and there is a trend toward increasing restrictiveness in such legislation. Local jurisdictions are rapidly taking the lead in tobacco use restrictions; close to 400 cities and counties have enacted smoking control ordinances (Pertschuk and Shopland, 1989).

Diverse groups that have some interest in smoking control have banded together, an increasingly common tactic, to present a united front to legislatures. Recruiting support from their various constituencies, such coalitions have been influential in convincing state legislators to increase cigarette taxes (Pertschuk and Shopland, 1989), provide smoke-free schools (Minnesota Department of Health, 1984; New Mexico Health and Environment Department, 1988; Pennsylvania Department of Health, 1986), and restrict sales of tobacco products to minors (Minnesota Department of Health, 1984; Pennsylvania Department of Health, 1986).

Enacting legislation at the local rather than the state level has been hailed as a method for controlling tobacco use while minimizing the influence of the tobacco lobby. This method has resulted in a number of local initiatives that range from control of minors' access to tobacco to mandated nonsmoking restaurant seating (Pertschuk and Shopland, 1989).

Interventions within the political sector are appealing for many reasons. First, smoking control activities may be implemented at multiple levels—by Federal, state, and local governments. Second, the political sector is the most likely sector to reach all members of the smoking population. Third, there is a high potential for synergy between the political sector and other subsystems within our society; legislative actions may be accompanied by economic resources for tobacco control activities, media attention, or cessation opportunities. A good example of how synergy can occur is found in the response of Iowans to a smoking ban on commercial airlines: A local group

## The Economic Sector

### Taxation

produced "quitters' survival kits," distributed them to smokers at the municipal airport on the effective date of the ban, and garnered a great deal of local publicity in the process.

In terms of the relative influence and importance of smoking control activities, there are three major aspects of the economic sector to review: taxation of individuals, workplace policies on smoking, and practices in other economic institutions (e.g., businesses).

The taxation of tobacco products has a predictable effect on tobacco use (Harris, 1982; Lewit and Coate, 1982). Studies have examined the decrease in smoking prevalence that accompanies a tax increase on tobacco products (Harris, 1982; Lewit and Coate, 1982; Warner, 1986); this type of decrease was particularly pronounced among adolescent and young smokers (Warner, 1986). In addition to a Federal cigarette tax, all states now have their own cigarette taxes (US DHHS, 1989), and some municipalities and counties have added taxes on tobacco products as well (Pertschuk and Shopland, 1989; US DHHS, 1989).

A few state governments have allocated a portion of the tobacco taxes to general health-promotion activities, and a few have dedicated some portion of the taxes to antitobacco activities (US DHHS, 1989). Early in 1989, California imposed a large additional tax on cigarettes (25 cents per pack), with a portion of the funds going to antitobacco research and activities (US DHHS, 1989). This strategy has a direct economic effect on smoking behavior and provides the resources to support a comprehensive, long-term intervention designed to alter tobacco use. Municipal and county government units could also examine taxation as a method of increasing resources for smoking control.

Taxation is an especially appealing form of smoking control intervention, because only tobacco users bear the costs. When accompanied by prevention activities in other channels, taxation appears to be especially effective in preventing young people from beginning to smoke. Its synergistic potential is enormous, because taxation can help fund smoking control activities in multiple intervention channels.

### Workplaces

Working adults spend nearly one-half of their waking hours on the job. They are strongly affected by the norms of the environment in which they work, and managers of workplaces are rapidly adopting policies to restrict tobacco use (Bureau of National Affairs, 1986; US DHHS, 1987).

Although restrictive policies are a key factor of worksite involvement in smoking control, there are other smoking cessation opportunities in the work setting as well. Worksites

have engaged in internal and external competitions, as well as incentive programs, to encourage employees to stop smoking (Cummings et al., 1988; Klesges et al., 1986; Rosen and Lichtenstein, 1977). The basic philosophy behind such an approach is that the workplace can provide a supportive environment for smoking cessation; furthermore, incentives for smokers to achieve and maintain cessation can add to the environmental support and lead even more smokers to try quitting.

Employers have collaborated with other groups to offer smoking cessation programs at the worksite, both on and off company time (Klesges et al., 1987; Omenn et al., 1988; Schilling et al., 1985). Synergy is assumed to occur when a program is offered in a setting where coworkers are also attempting cessation and providing support for fellow quitters. Results of such programs are generally comparable with those of clinic-based programs, but costs are considerably lower. Some employers have institutionalized regular smoking cessation programs at the worksite, in which employees are free to enroll at their own convenience. Other programs go even further and encourage the smoker's spouse and/or significant others to participate.

Typically, the American Cancer Society's annual Great American Smokeout has a segment designed for workplaces, and employers can use that opportunity to encourage smokers to quit for a day by organizing smoking cessation activities for the day. Similarly, the American Lung Association sponsors an annual Non-Dependence Day and produces many materials and suggestions for worksite participation in nonsmoking activities. The American Heart Association promotes a Sweet-Heart Day in February, with smoking cessation opportunities, advice, and materials incorporated in the day's activities.

Workplaces afford multiple opportunities to promote smoking cessation, and a restrictive smoking policy can establish not smoking as the appropriate behavior in a particular workplace. Smokers may be encouraged to attempt cessation as regular smoking control events are incorporated into the work environment. Incentives and competitions can increase smokers' motivation to try cessation. Activities that build on national or local events can reinforce the messages that a non-smoking environment is desirable and that the employer supports such an environment. As a group, these smoking control activities in the workplace can have a powerful influence on smokers.

### Other Economic Influences

*Restaurants.* A number of states have laws that require restaurants to offer nonsmoking sections (Hanauer et al., 1986; US DHHS, 1986). Public opinion surveys support the value of such restrictions. In one poll, 85 to 91 percent of restaurant-goers

expressed a desire for restrictions on smoking in restaurants (Gallup, 1983); in another, 39 percent of people surveyed said they would not return to a restaurant that did not offer a non-smoking section (Gallup, 1985).

**Insurance.** The insurance sector offers an economic incentive for smoking cessation and prevention that cuts across both employment and other business sites. Reductions in insurance premiums for nonsmokers and smoke-free workplaces offer individuals and organizations an added stimulus for smoking control activities. Although insurance premium reductions are not as influential as other sectors might be, they can add to the economic benefits that accrue from avoidance of tobacco use.

The insurance industry has reacted to the demonstration of the disease risks associated with smoking by discounting life insurance premiums for nonsmokers who purchased their own policies (Cowell, 1985). The vast majority of states now allow differential pricing of life insurance premiums according to smoking status (National Association of Insurance Commissioners, 1987a). Movement in other forms of insurance incentives has been slower. Health insurance providers have had difficulties in offering reduced premiums for nonsmokers because (1) the vast majority of health insurance policies are written for groups where smoking prevalence is difficult to determine; (2) actuarial data that support reduced health insurance premiums for nonsmokers are scarce; and (3) Federal regulations make it difficult for some health insurance plans (e.g., health maintenance organizations) to set premiums based on smoking status (US DHHS, 1989). Property and casualty insurance has fared somewhat better—homeowner policies are routinely offered at reduced premiums to nonsmokers. A few companies also provide nonsmoker discounts for automobile policies (National Association of Insurance Commissioners, 1987b).

To the extent that premium differentials by smoking status become institutionalized within society, and depending on the amount that insurance carriers reimburse for cessation treatment, a number of synergistic effects may result: (1) worksites and businesses could offer encouragement for nonsmoking; (2) worksites and businesses could make smoking cessation assistance available; and (3) the political sector could place economic sanctions on smokers.

The education sector can have an influence on children and their possible initiation of tobacco use. In the educational setting, there are opportunities to expose children to anti-tobacco information and provide them with nonsmoking role models. Educational interventions have focused on incorporation of tobacco information in school curricula; however,

#### The Education Sector

when such programs are provided without a companion community intervention, their effects appear to be small. Current research is examining ways to increase the influence of the educational programs by linking them with community and parent-related activities.

Educators can have an influence on children in ways other than the formal school curriculum. Educational facilities that are smoke-free for employees as well as for children can provide good models for nonsmoking environments. Students may participate in antitobacco activities through the schools; for example, many schools collaborate with advocacy groups to sponsor poster contests for children, sports activities with antitobacco sponsors, and other antismoking activities in the community.

Curricula that incorporate annual segments on tobacco use, a smoke-free environment, and annual smoking control activities in the community could be instrumental in developing the norm of not using tobacco. Activities in the educational sector can be synergistic with other sectors; for example, students may be enlisted to participate in a supervised "sting," where minors' success rates at purchasing tobacco products are documented, which can raise community awareness about the accessibility of tobacco products to minors, thereby melding the political and educational sectors.

#### The Communication Sector

The media play a pivotal role in smoking control activities. Mass media provide information to the public on facts and issues related to smoking, and they also influence public perceptions of appropriate behavior by portraying certain people either engaging in or abstaining from a particular behavior. The media have presented images and taken direct action against smoking. Media information dissemination has been designed to stimulate help-seeking behavior by smokers (Danaher et al., 1984; McGuire, 1984). Public service announcements have been used to encourage people to call a hotline for information (Cummings et al., 1986) and to recruit smokers into treatment programs (Jason et al., 1988; Mogielnicki et al., 1986).

Electronic media campaigns designed to assist people in achieving smoking cessation have been somewhat successful (Flay, 1987b). The American Lung Association "Freedom From Smoking in 20 Days" program has been used in many mass media markets, and the results appear quite favorable (Flay, 1987b). Print programs for smoking cessation have been successful as well (Cummings et al., 1987).

There is little doubt that the media can keep tobacco news and messages in the public eye; however, there is evidence that the media are somewhat constrained by the influence of the

tobacco companies. Media that carry tobacco advertisements give differential attention to tobacco issues compared with those that do not carry such advertisements (Warner, 1985; Whelan et al., 1981). In spite of these constraints, the media can be used for creative smoking control activities.

The communication sector is the conduit by which other sectors may publicize and disseminate their smoking control information and activities. The communication sector can be synergistic with all other sectors in four ways: (1) It can reinforce norms that promote smoking control by presenting positive images with respect to nonsmoking behavior and refusing to portray smoking as glamorous or desirable; (2) It can raise the public's awareness of smoking as an important issue; (3) it can provide direct information to the public about tobacco use; and (4) it can provide direct services in recruiting people into smoking cessation activities.

As a group, health professionals are an extremely influential force for reaching smokers. The vast majority of smokers see a physician each year (Ockene, 1987), providing an excellent opportunity for physicians to advise and counsel smokers to abandon their habit. Health professionals also can have an influential role in national policymaking and in promoting societal norms related to healthy living.

Increasingly, health professional associations are adopting an assertive stance with respect to controlling tobacco use. The American Medical Association has recognized smoking as a "serious health problem" since 1964 (Lundberg, 1985) and has advocated education about smoking since 1969 (Rosenberg, 1983). As early as 1964, the American Dental Association urged its members to educate patients about tobacco use, and it recently hosted its first national dental symposium on smoking cessation (McCann, 1989). The American Pharmaceutical Association has recommended that pharmacies not sell tobacco products (Smith and Fincham, 1989). Other health care provider groups, including nurses, have not taken official antismoking stands but are beginning to address the issue. Counseling against tobacco use is an appropriate topic for physicians' and dentists' continuing education, and many medical and dental schools are now incorporating such training into their disease prevention curricula.

Health professionals' advice about ceasing tobacco use is accompanied by inherent opportunities for expanding the effect of a single message about cessation. An office system that identifies smokers will help ensure that smoking patients receive repeated messages about smoking cessation and assistance with quitting. Smoke-free health care environments will support that goal by providing positive sanctions for a norm that health professionals are advancing.

#### The Health Professional Sector

In addition to multiple opportunities for intervention, health professionals' activities can lead to synergy with other intervention channels. For example, physicians have participated in the cancer society's Great American Smokeout by organizing activities, staffing information booths, and prescribing nicotine replacement therapy for their smoking patients. Some physician groups, such as Doctors Ought to Care, have participated in many visible antitobacco events. There is an increasing awareness of the importance of joint activities with other health professional groups in smoking control activities.

Just as physician input can be synergistic with other channels of smoking control activity, other sectors can be synergistic with physician efforts. The development of standards for physician management of smoking patients in the outpatient care setting and the implementation of these standards through the quality assurance auditing process are examples of how governmental and regulatory agencies can influence physician motivation and behavior. Physicians have an important role in establishing societal norms, particularly with respect to health issues, but societal norms and expectations are also important determinants of physician behavior. For example, the majority—about two-thirds—of prescriptions for nicotine gum as a smoking cessation aid are written at the patient's request rather than on the physician's initiative (US DHHS, 1989).

Three national voluntary groups, the American Cancer Society, the American Heart Association, and the American Lung Association, have a rich history of smoking control efforts. In addition to these three groups, a number of other voluntaries, such as Americans for Nonsmokers' Rights and Fresh Air for Nonsmokers, emphasize smoking control activities in their mandates. These organizations are influential in that their staffs and volunteers form networks that extend to almost all geographic sections of the United States.

The cancer society, heart association, and lung association have a variety of events and activities that support tobacco control. Each of the groups has a major annual event that emphasizes nonsmoking. The American Cancer Society sponsors the Great American Smokeout in November; the American Heart Association promotes SweetHeart Day in February; and the American Lung Association coordinates activities around Non-Dependence Day in July. The voluntaries have also produced various smoking cessation materials and free or low-cost programs for smokers who are trying to quit. Special programs have been developed for some targeted populations, such as low-income pregnant women—the cancer society's "Special Delivery" and lung association's "Freedom from Smoking for You and Your Baby." The voluntary groups also offer self-help programs.

#### The Health Voluntaries' Sector

The strength of the health voluntaries lies in their networks of volunteers throughout the country, and antitobacco activities that build on that strength are likely to be successful. Door-to-door fundraising campaigns also serve as public education opportunities. Collaboration with other sectors, such as smoking cessation media campaigns, may be successful (Flay, 1987b). Multiple opportunities for smokers to attempt cessation are available, because the voluntaries provide ongoing cessation services and resources. Public information campaigns detailing the available resources will help ensure that smokers are aware of the assistance that is available in any geographic location.

In terms of synergism, voluntaries may be considered the resource centers of diverse cessation activities and events in the community. To the extent that information on smoking control activities, on smoking cessation opportunities and materials, and on special communitywide events is widely available and publicized, this sector helps to coordinate all sectors of the community in promoting smoking control efforts.

## CONCLUSIONS

- Smoking control strategies have evolved and expanded during the last 40 years as our understanding of smoking behavior and its risks has developed.
- Attempts to educate smokers and treat them individually have given way to more comprehensive efforts to treat both the individual smoker and the environment within which smoking takes place.
- Multiple channels and approaches to all sectors of the social environment characterize the state of the art in comprehensive control of tobacco use. This approach is used because different channels may reach different groups of smokers and because the synergism of multiple inputs to the smoker may create an effect greater than the sum of the effects of the individual channels.

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## Chapter 3

# Smoking Prevalence and Lung Cancer Death Rates

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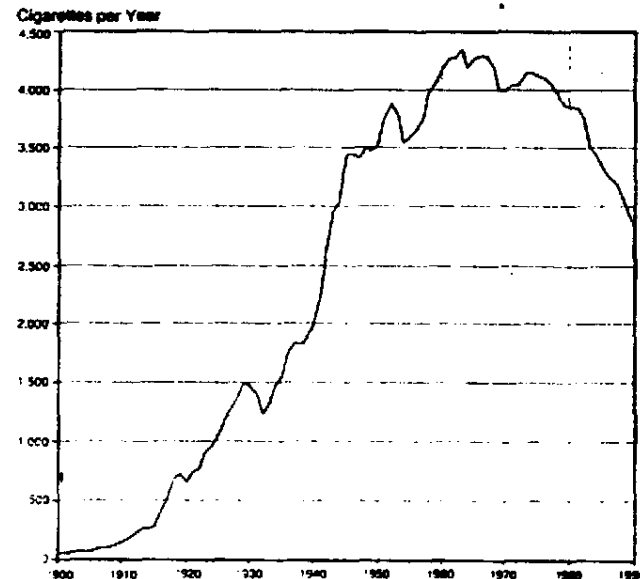
## Chapter 3

# Smoking Prevalence and Lung Cancer Death Rates

### INTRODUCTION

The use of cigarettes, in contrast to other tobacco products, is a behavior that has developed relatively recently. Widespread use of cigarettes has been predominantly a 20th century phenomenon, with per capita consumption of cigarettes rising from 54 in 1900 to a peak of 4,345 in 1963 and then declining (Shopland et al., 1990) (see Figure 1). [Note: The data points used for plotting all figures in this chapter are listed in Appendix A.]

Figure 1  
U.S. per capita cigarette consumption for adults, aged 18 and older (1900 to 1990)



Other chapters of this monograph address the social and environmental influences that have produced these changes in per capita consumption over time. This chapter describes the changes in smoking prevalence that occurred during this

century and links them to observed changes in lung cancer death rates. A model for predicting future lung cancer death rates is presented also.

The prevalence of cigarette smoking is not spread uniformly across the U.S. population. There are marked differences in smoking prevalence across gender, racial, educational, and age groupings in the current population, and these differences have varied markedly across the first nine decades of this century. The risk of developing lung cancer is defined predominantly by past smoking exposure rather than by current smoking status. For these reasons, the data presented in this chapter are arranged by 10-year birth cohort. (A birth cohort is a group of individuals born during a specific span of calendar years.)

By following the changes in smoking behavior and lung cancer occurrence in a cohort as it ages, one is able to construct an accurate picture of the cumulative smoking history of the cohort and compare it with the resultant lung cancer occurrence in the same cohort. The more traditional approach, presenting data from multiple cross-sectional surveys done in different calendar years by the age of the individual surveyed at the time of the survey, leads to a biased impression of the changes in smoking prevalence that occur with age and an underestimation of the past smoking behavior of the older segments of the current population. When age-specific rates from multiple cross-sectional studies are compared to one another, the implicit assumption is that attained age (rather than calendar year of birth) is the dominant determinant of the rate being measured. For smoking behavior, however, calendar year of birth has a major influence on the possibility that an individual will become a cigarette smoker and on the duration of that smoking behavior. The individuals who constitute a given age group in cross-sectional samples drawn many years apart will belong to different birth cohorts. To compare the cross-sectional smoking prevalences at a given age without considering the peak prevalences of the birth cohorts that they represent distorts the true relationship between smoking behavior and age.

The excess death rates in cigarette smokers compared to nonsmokers lead to a diminishing fraction of ever-smokers being measured in a birth cohort as the population ages. Current measures of current and former smokers in older age groups will then underestimate the true prevalence of smoking of the same birth cohort several decades earlier. Since past rather than current smoking behavior causes lung cancer, and since the bulk of the U.S. lung cancer deaths occur among those same older segments of the current population, an accurate description of their smoking behavior is essential to

the development of a model that relates smoking behavior to lung cancer death rates.

#### ANALYSIS OF SMOKING BEHAVIOR

This section characterizes smoking behavior in the United States between 1901 and 1987. Smoking prevalence is examined over time, by 10-year birth cohort, gender, and race. This information was produced from analyses of the National Health Interview Surveys (NHIS) conducted in 1970, 1978, 1979, 1980, and 1987. Because of its large sample size and high response rate (typically greater than 95 percent), the NHIS was used for estimates of smoking prevalence in the United States. The NHIS data sets used here are the only NHIS data sets available for computer analysis that include information regarding age of initiation and cessation of smoking—the two variables necessary to this analysis for constructing the past smoking behavior of a birth cohort from recent cross-sectional data.

Similar analyses have been reported previously in the Surgeon General's Reports (US DHHS, 1980 and 1985). The 1980 report included an analysis of the 1978 NHIS, with prevalence estimates through 1978. The 1985 report included analysis of the 1978, 1979, and 1980 NHIS combined, and also reported prevalence through 1978. The current analyses update the previous analyses by providing estimates through 1987 (an additional 9 years) and make use of the earlier 1970 data, which are likely to provide more accurate estimates of smoking behavior prior to 1970. This greater accuracy may be most applicable to earlier birth cohorts (e.g., people born from 1901 to 1910), which experienced significant mortality prior to 1978 (see discussion below). In addition, of all the NHIS samples, the 1970 NHIS is the largest, with 116,466 cases overall, including smoking data for 76,675 of these cases. The total number of cases for the other surveys used for this analysis were as follows: 1978, 12,111; 1979, 26,271; 1980, 11,333; and 1987, 22,043.

The analyses reported here rely mainly on responses to three questions: "How old were you when you first started smoking cigarettes fairly regularly?", "Do you smoke cigarettes now?", and "About how long has it been since you smoked cigarettes regularly?" The wording of these questions remained essentially identical across all surveys; however, the order of the questions and coding of responses may have resulted in slight differences in the categorization of smokers as *regular* versus *occasional* smokers. *Occasional* smokers typically are defined as those who *volunteer* that they never smoked cigarettes regularly, and thus they do not consistently report an age of onset and/or age of quitting. Because of the inconsistency of reporting, these respondents, when identifiable, were treated as *never-smokers* in these analyses.



Another difference among the five NHIS data sets used here is the source of responses—that is, self or respondent proxy. Of those responding to the smoking questions, the proxy response rates among those over age 17 in the surveys are: 1970, 39.0 percent; 1978 to 1980, 0.5 percent; and 1987, 22.2 percent. Proxy respondents typically are thought to report smoking status accurately but to underreport the number of cigarettes smoked per day and to be less knowledgeable about the age of onset and cessation of smoking (U.S. DHHS, 1990).

Diagnostic analyses regarding the effects of using both proxy reports and self-reports in the 1970 NHIS demonstrate that estimates of age of initiation and age of cessation, by cohort and by cohort and gender, generally differ by less than 1 percentage point when based on proxy versus self-reports. In most cases, proxy reports result in slightly higher ages of initiation and cessation. This suggests that proxy reporting does not substantially affect cohort trends in smoking over time as reported here. Use of only self-reports for estimates of smoking prevalence results in smoking rates for females that are generally less than 2 percentage points higher than those reported here for all respondents (self and proxy). Among males, for whom the proportion of proxy reports is considerably higher, the use of only self-reports results in smoking prevalences between 0 and 6.2 percentage points higher, depending on the cohort. While part of the discrepancy is likely attributable to underreporting of smoking behavior by proxy respondents, those who respond by proxy have been noted to be generally younger, employed, and never married or married (as distinguished from divorced, separated, or widowed), and to have higher incomes and fewer health problems (Crane and Marcus, 1986). These characteristics suggest that those responding by proxy may indeed have lower smoking rates; thus, part of the difference between self-reports and all reports may reflect real differences in smoking status.

Because this analysis estimates smoking prevalence beginning in 1905, it relies on recall of smoking behavior many years before the surveys. In general, the data used are those collected closest to the year for which smoking prevalence is being estimated. Two assumptions guided this decision: First, recall of previous smoking behavior is likely to be better when the survey is conducted closer in time rather than further from the year being estimated; second, each cohort experiences mortality as time passes, with the earlier cohorts experiencing greater mortality. Using earlier data to estimate smoking behavior assures that more members of each cohort are available to provide a more accurate picture of the cohort's smoking behavior in years past. Since both current and former smokers

have higher age-specific mortality rates than nonsmokers overall, a birth cohort has a progressively lower percentage of smokers and former smokers and a higher percentage of never-smokers as the individuals in the cohort grow older. Therefore, measurements of smoking behavior made earlier in time for the oldest cohorts provide a more accurate picture of their smoking behaviors during the middle part of the century than do current measurements.

In keeping with this, 1970 NHIS data were used for estimates of smoking prevalence for time points up to and including 1970; the 1978, 1979, and 1980 NHIS data were combined for estimates of smoking prevalence in 1975; the 1979 and 1980 NHIS data were combined for estimates of smoking prevalence in 1980 (with the assumption of no changes in smoking status in 1980 for those who responded in 1979); and the 1987 NHIS data were used for estimates of smoking prevalence in 1985 and 1987. There were two exceptions to this scheme. Because the 1951 to 1960 birth cohort includes members who were only 10 years of age in 1970 (and thus did not respond to the smoking questions), 1978 through 1980 data were used for estimates of smoking for this cohort prior to and including 1970. Similarly, the 1987 data were used to provide estimates of smoking for all time points for the 1961 to 1970 birth cohort.

In the 1980 Surgeon General's Report on smoking (U.S. DHHS, 1980), there is an attempt to quantify the potential underestimation of smoking prevalence for earlier cohorts attributable to the differential mortality between smokers and nonsmokers. Applying the author's line of reasoning to this case, the group for which the mortality bias would have the most effect is the 1901 to 1910 cohort, which was aged 60 to 69 when surveyed in 1970. According to insurance life tables reported by Cowell and Hirst (1979), a male cigarette smoker at age 32 has an 80 percent chance of surviving to age 60, while a nonsmoker has a 93 percent chance. Data from the 1970 NHIS indicate that this cohort reached its peak smoking prevalence of 62 percent in 1940. Given the estimated mortality differences between smokers and nonsmokers, the actual smoking rate may have been as high as 66 percent. Thus, the estimated underreporting for this cohort is about 4 percentage points. The underestimate would be less for younger cohorts. The estimated survival rates to age 60 for female smokers and nonsmokers are 91 percent and 93 percent, respectively (Hammond, 1966), which would result in a negligible underestimation (less than 1 percentage point). These adjustments to the prevalence estimates assume that smokers remain continuous smokers and derive no survival advantage from cessation, which provides a worst-case estimate of bias.

SMOKING  
PREVALENCE

As noted previously, the sample sizes of the data sets used for these analyses varied, so the confidence intervals for estimates vary. For most groups and time points reported, 95 percent confidence intervals are less than  $\pm 2$  percentage points (assuming a simple random sample; i.e., not taking into account the complex sampling strategy of the NHIS). However, estimates for the years 1985 and 1987 used the 1987 NHIS and are based on considerably fewer respondents than other estimates. Confidence intervals for estimates in 1985 and 1987 are in the range of  $\pm 2$  to 4 percentage points for most groups. These generalizations hold for smoking estimates for all males, all females, white males, and white females. Sample sizes for blacks of both sexes are considerably smaller, and confidence intervals for estimates are consequently much larger, in the range of  $\pm 4$  to 7 percentage points for time points prior to 1985, and in the range of  $\pm 5$  to 9 percentage points for estimates of smoking in 1985 and 1987. Sample sizes for the three major data sets—by cohort, gender, and race—are presented in Table 1.

Figures 2 through 7 show changes in prevalence of cigarette smoking over time among successive birth cohorts for all males, all females, white males, black males, white females, and black females in the United States. As shown in Figure 2, among males, the 1911 to 1920 and 1921 to 1930 birth cohorts achieved the highest peak prevalences, at 65.9 percent and 66.1 percent, respectively. According to these data, the 1901 to 1910 cohort reached a peak smoking rate of 61.8 percent, which should be adjusted upward somewhat because of the differential mortality likely to have occurred between smokers and non-smokers prior to the survey in 1970. The overall exposure to cigarettes appears to be different for these three cohorts, however, because of differences in the rates of cessation. For example, when the 1901 to 1910 cohort was aged 55 to 64 in 1965, its smoking rate was 45.0 percent. The comparable rate for the 1911 to 1920 cohort in 1975 was 39.8 percent, while for the 1921 to 1930 cohort, the rate in 1985 was 32.5 percent. Thus, although the three cohorts achieved similar peak rates, cessation was progressively greater for the later cohorts, resulting in fewer total years of exposure to cigarettes for the later cohorts at any given age. Birth cohorts after the 1931 to 1940 cohort experienced successively lower peak prevalence (52.3 percent, 39.6 percent, and 32.4 percent, respectively).

Figure 3 presents the smoking prevalence for successive birth cohorts of U.S. women and clearly demonstrates that women began to smoke in substantial numbers much later in the century than did men. The earliest birth cohort of men (1901 to 1910) showed marked initiation of smoking during adolescence (around 1915 to 1920) and had a high peak prevalence. In contrast, the same birth cohort of women took up smoking much more slowly (around 1925 to 1930) and had a

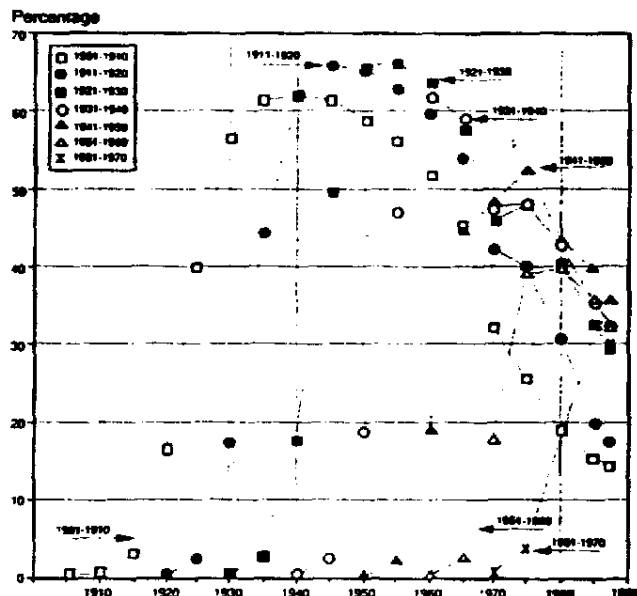
Table 1  
Sample sizes for three major NHIS data sets, by birth cohort, gender, and race

	Male			Female		
	All	White	Black	All	White	Black
Birth Cohorts, 1970 NHIS						
1901-1910	3,363	3,065	256	4,677	4,215	440
1911-1920	4,715	4,331	334	5,934	5,350	525
1921-1930	5,484	4,991	419	6,864	6,129	696
1931-1940	5,168	4,663	438	6,532	5,862	762
1941-1950	6,690	6,008	586	8,409	7,332	941
Birth Cohorts, 1978-80 NHIS						
1901-1910	1,511	1,368	107	2,031	1,839	178
1911-1920	2,520	2,290	200	3,261	2,947	282
1921-1930	3,194	2,922	231	3,768	3,366	335
1931-1940	3,048	2,734	265	3,739	3,260	412
1941-1950	4,185	3,765	342	4,866	4,249	512
1951-1960	5,172	4,572	509	6,137	5,284	747
Birth Cohorts, 1987 NHIS						
1901-1910	331	289	37	831	754	74
1911-1920	833	731	96	1,412	1,240	159
1921-1930	1,084	937	135	1,583	1,345	220
1931-1940	1,125	957	134	1,399	1,145	221
1941-1950	1,757	1,501	205	2,196	1,821	324
1951-1960	2,144	1,839	242	2,936	2,318	528
1961-1970	1,548	1,305	187	2,033	1,581	376

Source: National Health Interview Survey (NHIS) 1970, 1978, 1979, 1980, 1987 Public Use Data tapes. National Center for Health Statistics.

very low peak prevalence. Clearly the increase in per capita consumption of cigarettes during the first part of the century was confined largely to males, while the rapid increase in per capita consumption that occurred just prior to and during World War II involved both men and women. The highest peak prevalence among women occurred for the 1931 to 1940 cohort, with a rate of 43.9 percent in 1965. The peak for the 1921 to 1930 cohort was only slightly lower (42.5 percent in 1960). Thus, the highest peak prevalence for women occurred about 10 years behind the peak prevalence for men. Notable among females is the considerably lower prevalence of smoking

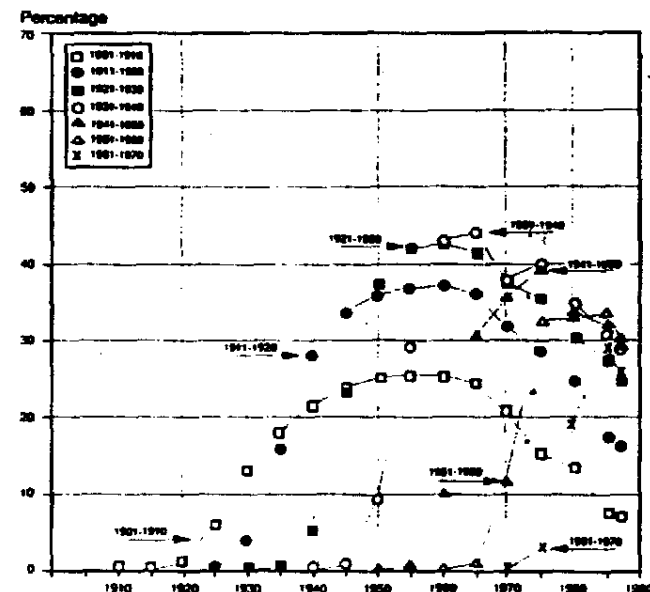
Figure 2  
Changes in prevalence of cigarette smoking among successive birth cohorts of U.S. males, 1900 to 1987



in the 1901 to 1910 cohort than in all other cohorts (with a peak of only 25.4 percent in 1955). While the peak prevalence declined considerably for males among those cohorts after 1931 to 1940, the decline has been more modest for females (the peak was 39.3 percent for the 1941 to 1950 cohort, 33.6 percent for the 1951 to 1960 cohort, and 29.2 percent for the 1961 to 1970 cohort).

One impact of this difference in the smoking behavior of the same birth cohorts of men and women is a difference in the current and future lung cancer death rates. Lung cancer occurrence is roughly proportional to the cumulative smoking experience of a cohort (the area under the prevalence curve for the cohort), but lung cancer occurs predominantly in the older age groups of the population. Therefore, overall lung cancer death rates for the U.S. population reflect largely deaths among individuals from ages 50 to 80. The men who are in this age group currently include those cohorts that have the highest peak prevalence of smoking and the greatest cumulative exposure to smoking. The cohorts now entering the 50 to 80 age range, when most lung cancers occur, have a lower peak

Figure 3  
Changes in prevalence of cigarette smoking among successive birth cohorts of U.S. females, 1900 to 1987



and cumulative smoking exposure than the cohorts they are replacing. This should result in a decline in the number of lung cancers caused by smoking, and the timing of the projected decline is discussed later in this chapter.

The picture for women is substantially different. Peak and cumulative smoking exposures are substantially lower for those birth cohorts that are currently in the 50 to 80 age range, and so are lung cancer death rates. However, the women who are entering this age range (those cohorts born after 1930) have substantially greater peak and cumulative smoking exposure than those women whom they are replacing (the cohorts born from 1901 to 1930), and overall lung cancer death rates for women are continuing to increase steeply and will not begin to decline until much later than those for men.

Figures 4 and 5 present smoking data for the same cohorts of white and black males. There are several important differences between the smoking patterns for white males and black males that are evident from a comparison of these figures. First, the adoption of cigarette smoking in the early part of this century was somewhat slower among black males than among

Figure 4  
Changes in prevalence of cigarette smoking among successive birth cohorts of white U.S. males, 1900 to 1987

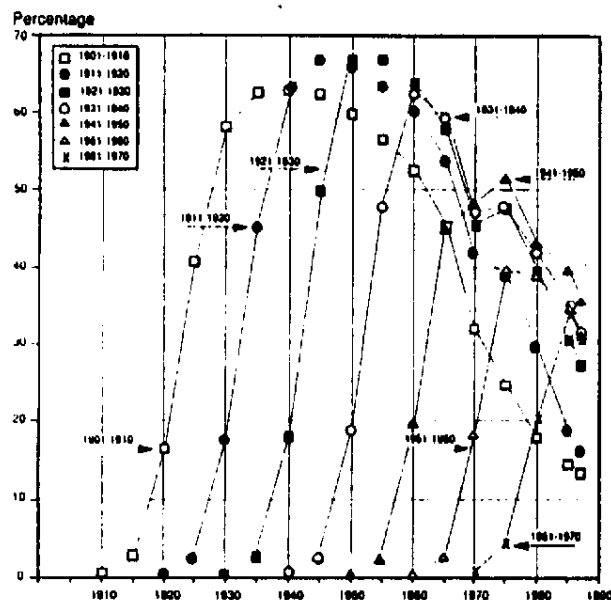
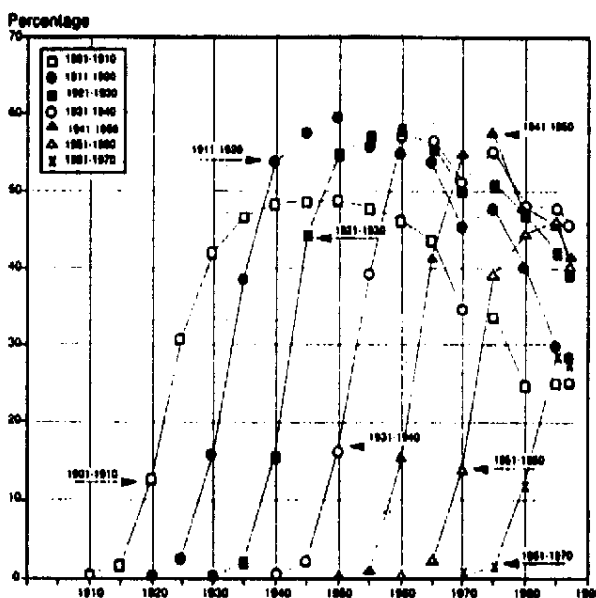


Figure 5  
Changes in prevalence of cigarette smoking among successive birth cohorts of black U.S. males, 1900 to 1987



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white males. The peak prevalence of smoking for the oldest cohort of black males is dramatically lower than that for the same cohort of white males, and the peak prevalence for each of the next two birth cohorts is also lower for black males. The peak prevalences for the 1931 to 1940 cohorts are similar and the peak prevalences for the cohorts born after 1940 are higher for black males than for white males. It is not until the 1951 to 1960 birth cohort that there is any evidence of a decline in peak prevalence. This suggests that the influences that drive the initiation of smoking occurred somewhat later in this century among the black male population; but among more contemporary cohorts, they have exerted a stronger influence on the black male population than on the white male population.

A second major difference between these two patterns is the width of the prevalence peaks. The number of years that a birth cohort spends at or close to its peak before beginning to decline is much greater for black males than for white males, resulting in the black male cohorts' having a greater cumulative smoking exposure than would be estimated from an examination of their peak prevalence alone. There appears to have been very little smoking cessation among black males until they reached a substantially greater age than their white birth-cohort peers. These two differences in the prevalence patterns are consistent with the lag in black male lung cancer death rates, compared to white male lung cancer death rates, that was observed early in this century, which has now reversed to produce current lung cancer death rates for black males that are substantially above those for white males.

A third difference relates somewhat to the longer duration of peak prevalence for black males. White males in all of the older birth cohorts began to quit in significant numbers in the mid-1950's, but cessation did not become evident among black male cohorts until the middle to late 1960's. A steep decline is evident in each of the three oldest white male cohorts (those that had already reached their peak) by the mid-1950's, and the onset of the steep part of the decline seems to be more closely related to the calendar year than to age. This timing coincides with the drop in per capita tobacco consumption that occurred during the mid-1950's and which has been attributed by Warner (1981) and others to the widespread publicity on smoking-related disease risks that occurred after publication of the first major prospective mortality studies on smoking risks. The same three cohorts of black males do not show a similar decline in prevalence until the 1970 data point, where all three cohorts show a steep decline from 1965. This time point also coincides with a drop in per capita cigarette consumption that occurred from 1967 to 1970 and which has been attributed to

the antismoking advertisements that were on television at that time to counter cigarette commercials. This difference in the timing of the decline in prevalence between white and black males suggests that the knowledge of the disease risks associated with smoking may not have effectively penetrated into the black community until much later than it reached the white community.

Figure 6 shows smoking prevalence for white female cohorts and closely resembles Figure 3 (all females). Figure 7 (black females) shows some general similarities to the pattern for white females.

From 1950 to the present, the age-adjusted cancer mortality rate for all sites combined has been increasing. However, when these rates are calculated for "all other cancers" (excluding lung cancer) the overall cancer death rate has been constant or declining, as shown in Figures 8 through 13. This decline is evident for the total male and female populations (Figures 8 and 11), and it is evident for the subgroups of white males, white females, and nonwhite females (Figures 9, 12, and 13); however, the death rates for "all other cancers" among nonwhite males are still increasing slightly. [Note: For all analyses in this chapter, the designations "black" and "non-white" may be considered interchangeable, as black men and women constitute about 90 percent of the nonwhite population studied.]

This section of Chapter 3 examines trends in mortality from primary cancers of the lung between 1950 and 1985. Its purpose is to review the changes in lung cancer death rates as a reflection of the changes in smoking prevalence described above.

Data from the National Death Tapes, supplied by the National Center for Health Statistics, were used to calculate mortality rates. These rates were age-adjusted according to the direct method (Lilienfeld, 1967), with the 5-year age distribution of the total 1970 U.S. population as the standard. Except where noted, rates are presented as cases per 100,000 population. The analysis is based on the same birth cohorts as those used in the previous section on smoking prevalence.

Lung cancer mortality rates, by 10-year birth cohort, gender, and race, are presented in Tables 2 through 7. Lung cancer mortality becomes measurable when a cohort reaches a minimum age of 35, and it rises sharply as age increases. One can compare age-specific lung cancer death rates for different birth cohorts by using these tables and matching the death rate for one birth cohort with the death rate recorded 10 years earlier for the preceding birth cohort. Each birth cohort is 10 years younger than the preceding one, so the rates for the

## LUNG CANCER MORTALITY

## Methodology

## Mortality Rates for Lung Cancer

Figure 7  
Changes in prevalence of cigarette smoking among successive birth cohorts of black U.S. females, 1900 to 1987

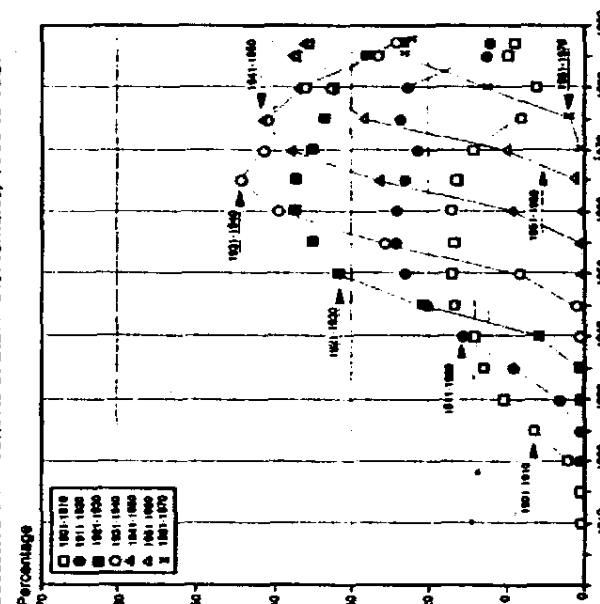


Figure 6  
Changes in prevalence of cigarette smoking among successive birth cohorts of white U.S. females, 1900 to 1987

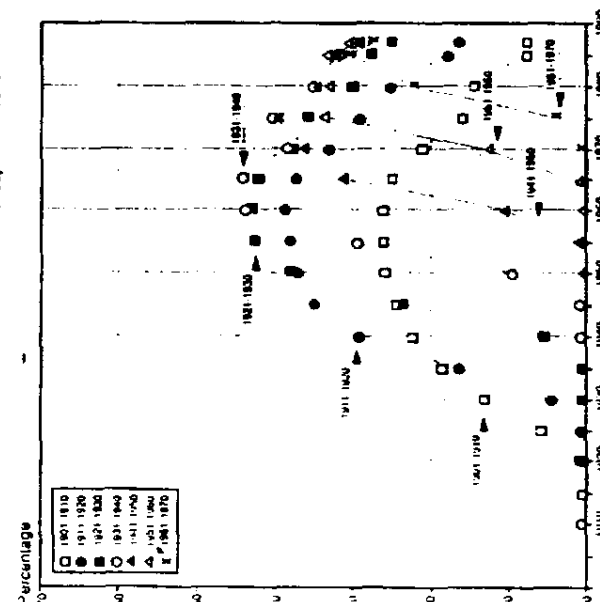
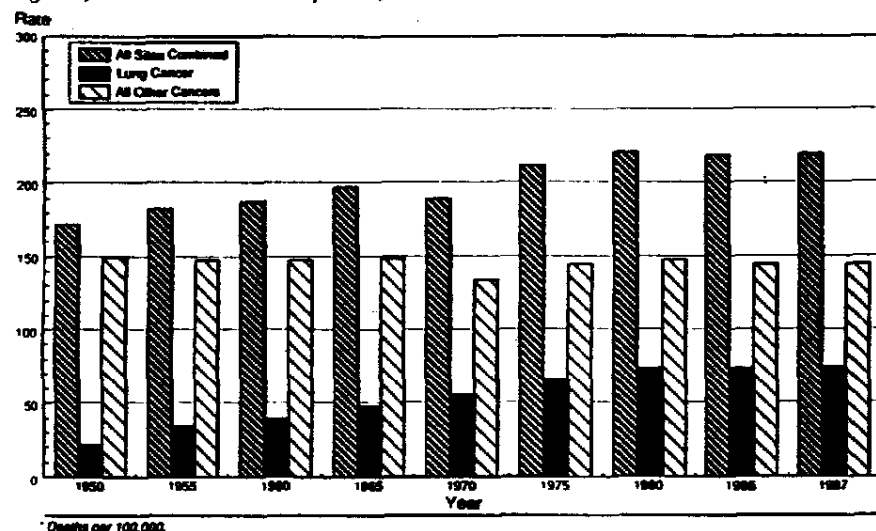


Figure 8  
Age-adjusted cancer mortality rates,\* all males



preceding cohort at a given age will have occurred 10 years earlier. The age-specific death rates are presented by birth cohort in Tables 8 through 13. Successive cohorts of males experienced higher age-specific mortality rates through the 1921 to 1930 cohort. However, beginning with the 1931 to 1940 cohort, the age-specific rates have been declining. This is a reflection of the downward trend in cigarette smoking that began with the 1931 to 1940 cohort of males in the United States.

Table 4 shows the mortality rates for lung cancer among nonwhite males. The rates for nonwhite males born during the period from 1901 through 1910 are somewhat lower than those for all U.S. males and for white males. However, for each subsequent cohort, the nonwhite male death rates from lung cancer are considerably higher than those for all males. The higher rates among nonwhites may be explained in part by the longer maintenance of the smoking habit and higher rates of smoking during the critical older ages.

The lung cancer death rates for women, first measurable at age 35, are considerably lower than those for males and rise more slowly with age in the older birth cohorts (Table 5). While the rates for males began to decline with the 1931 to 1940 cohort, the rates continued to rise among women for successive cohorts through 1931 to 1940.

Figure 9  
Age-adjusted cancer mortality rates,\* white males

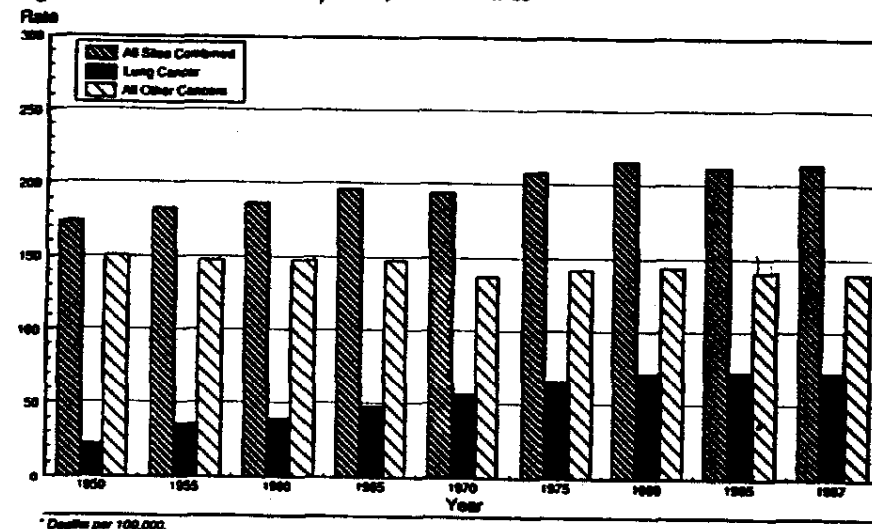


Figure 10  
Age-adjusted cancer mortality rates,\* nonwhite males

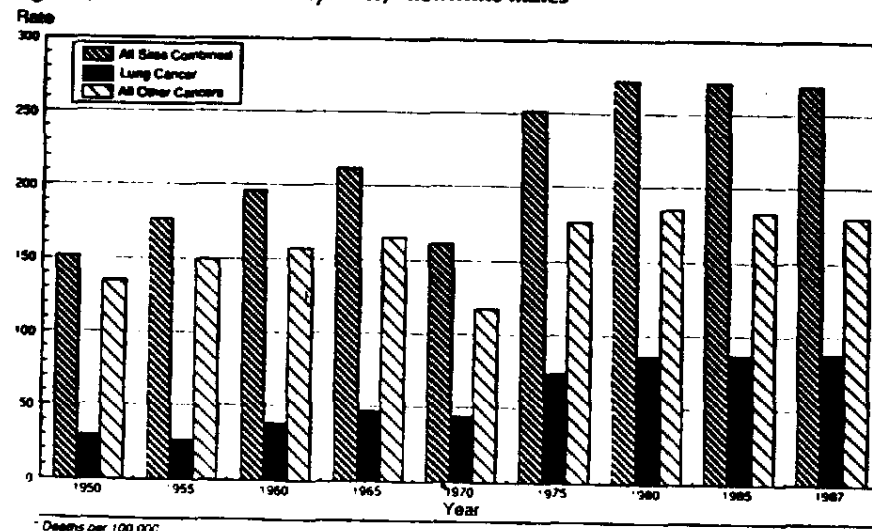
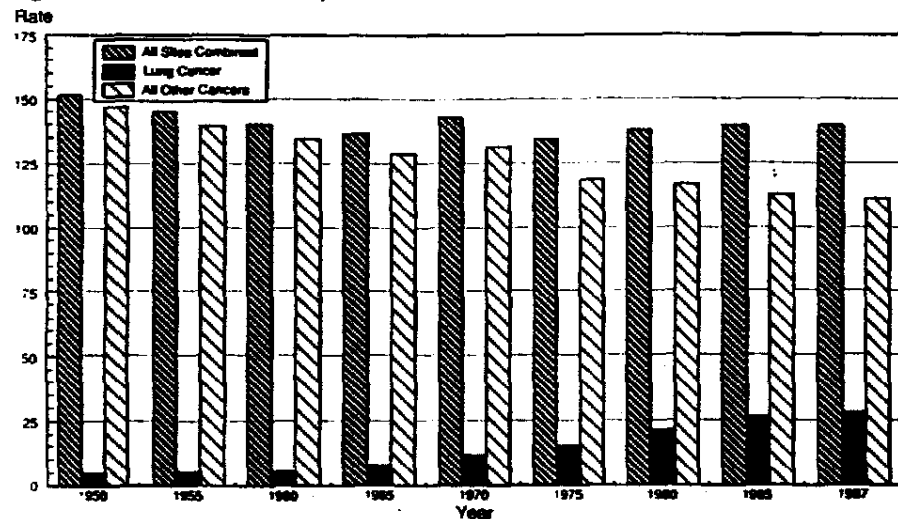


Figure 11  
Age-adjusted cancer mortality rates,\* all females

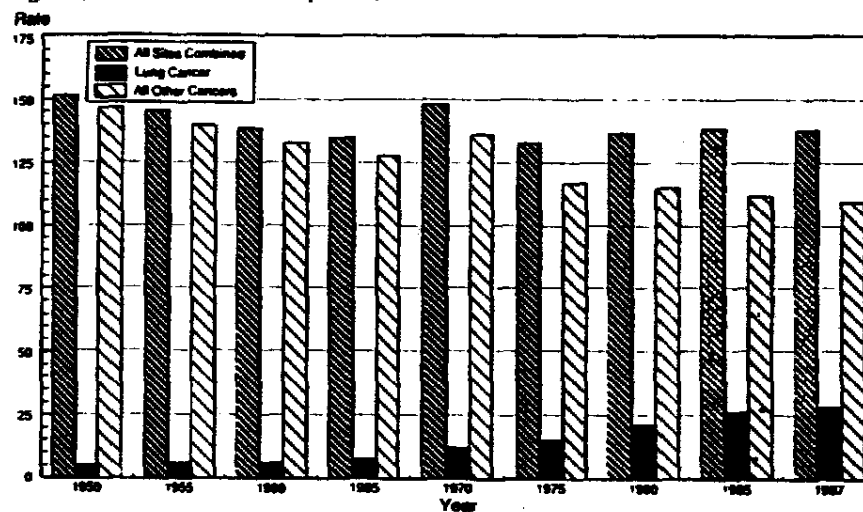


\*Deaths per 100,000.

The U.S. white female lung cancer mortality rates (Table 6) are very close to those for all females (Table 5). The lung cancer mortality rates among the nonwhite female cohorts before 1921 to 1930 (Table 7) were generally, though not consistently, lower than among the whites; however, at that point they seem to catch up and then slightly surpass the white females. Smoking prevalence data suggest that lung cancer mortality would be lower for nonwhites than for whites in the earliest two cohorts.

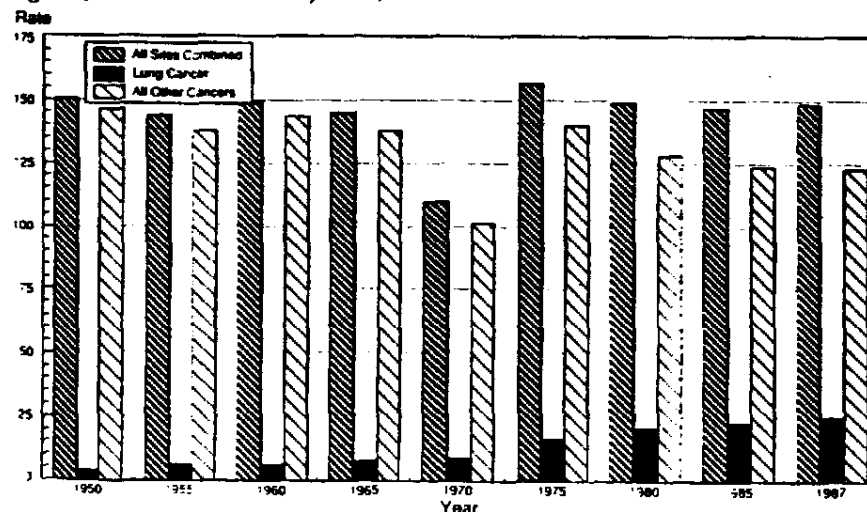
Tables 8 through 13 provide a retabulation of data from Tables 2 through 7, as age-specific rates with percentage of change between cohorts. This allows a ready comparison of the lung cancer experience of the different cohorts at the same ages. For example, when males in the 1911 to 1920 cohort were aged 40 to 49, their lung cancer mortality rate was higher than that of the 1901 to 1910 cohort at the same age. The rates continued to rise as the 1921 to 1930 cohort reached age 40 to 49; however, the rates declined slightly for the 1931 to 1940 cohort. This pattern is seen for all males, regardless of race. At ages 50 to 59, the rates rose considerably less between the 1911 to 1920 and 1921 to 1930 cohorts than they did between the 1901 to 1910 and 1911 to 1920 cohorts (for all males, 13 percent compared with 32 percent), suggesting a leveling off of lung cancer mortality among this age group.

Figure 12  
Age-adjusted cancer mortality rates,\* white females



\*Deaths per 100,000.

Figure 13  
Age-adjusted cancer mortality rates,\* nonwhite females



\*Deaths per 100,000.

Table 2  
Lung cancer mortality rates, 1950 to 1985, for all males born 1901 through 1950, by birth cohort

Year	Lung Cancer Mortality,* by Birth Cohort				
	1901-1910	1911-1920	1921-1930	1931-1940	1941-1950
1950	17.0				
1955	47.8				
1960	91.1	24.0			
1965	159.3	58.7	13.2		
1970	259.7	120.1	35.4		
1975	363.4	200.5	74.3	14.0	
1980	470.7	308.2	135.3	33.9	
1985	543.0	415.9	220.3	67.0	9.9

\* Deaths per 100,000.

Table 3  
Lung cancer mortality rates, 1950 to 1985, for white males born 1901 through 1950, by birth cohort

Year	Lung Cancer Mortality,* by Birth Cohort				
	1901-1910	1911-1920	1921-1930	1931-1940	1941-1950
1950	17.1				
1955	48.9				
1960	90.2	22.6			
1965	159.4	58.8	12.2		
1970	259.9	115.2	32.7		
1975	365.2	193.9	69.3	12.6	
1980	473.5	301.1	128.4	30.9	
1985	548.4	409.5	211.9	62.2	9.0

\* Deaths per 100,000.

#### Smoking Prevalence And Lung Cancer Mortality

Figures 14 through 33 offer a closer look at the effect of smoking and at trends in lung cancer mortality, by birth cohort. For each gender and race group by birth cohort, the figures show changes over time in the percentage of those currently smoking, percentage of those who have ever smoked, and rates of lung cancer mortality, expressed as number of deaths per 10,000 population.

Table 4  
Lung cancer mortality rates, 1950 to 1985, for nonwhite males born 1901 through 1950, by birth cohort

Year	Lung Cancer Mortality,* by Birth Cohort				
	1901-1910	1911-1920	1921-1930	1931-1940	1941-1950
1950	18.1				
1955	54.1				
1960	96.8	36.7			
1965	158.7	77.0	22.3		
1970	257.8	166.2	59.0		
1975	347.8	282.2	117.1	24.1	
1980	445.1	374.5	194.7	54.8	
1985	511.6	475.3	288.7	98.4	18.5

\* Deaths per 100,000.

Table 5  
Lung cancer mortality rates, 1950 to 1985, for all females born 1901 through 1950, by birth cohort

Year	Lung Cancer Mortality,* by Birth Cohort				
	1901-1910	1911-1920	1921-1930	1931-1940	1941-1950
1950	3.5				
1955	7.2				
1960	12.0	6.1			
1965	21.9	13.9	4.4		
1970	40.0	30.1	12.1		
1975	65.8	54.4	26.6	7.0	
1980	101.6	91.5	52.1	16.9	
1985	133.3	141.8	91.2	34.8	5.6

\* Deaths per 100,000.

Small sample sizes create some difficulty in interpreting findings in smoking behavior among the black male cohorts (Figures 15, 17, 19, 21, and 23). For example, estimates for the 1901 to 1910 cohort in 1985 and 1987 are based on only 37 respondents. This results in a 95 percent confidence interval of approximately  $\pm 14$  percentage points (assuming a random sample). Regardless, the following trends appear: For the four oldest cohorts (1901 to 1940), there is an apparent rise



Table 6  
Lung cancer mortality rates, 1950 to 1985, for white females born 1901 through 1950, by birth cohort

Year	Lung Cancer Mortality,* by Birth Cohort				
	1901-1910	1911-1920	1921-1930	1931-1940	1941-1950
1950	3.5				
1955	6.8				
1960	11.8	6.0			
1965	21.7	13.8	4.2		
1970	40.5	30.1	11.7		
1975	64.7	55.4	26.5	6.8	
1980	103.4	92.8	51.6	16.5	
1985	136.4	145.6	91.7	35.1	5.5

\* Deaths per 100,000.

Table 7  
Lung cancer mortality rates, 1950 to 1985, for nonwhite females born 1901 through 1950, by birth cohort

Year	Lung Cancer Mortality,* by Birth Cohort				
	1901-1910	1911-1920	1921-1930	1931-1940	1941-1950
1950	3.6				
1955	10.5				
1960	13.1	7.2			
1965	23.8	14.5	5.9		
1970	35.0	29.7	14.9		
1975	79.3	45.8	28.1	8.0	
1980	83.8	79.6	55.8	19.5	
1985	101.2	108.7	87.7	33.0	6.2

\* Deaths per 100,000.

between 1970 and 1985 in the number who have ever smoked. In addition to the small sample size, slight changes in survey methodology over the different years of administration (as described previously) could cause these results. Still, these increases deserve further exploration.

Also of note are the rates of lung cancer relative to white males. Although the prevalence of current smokers and ever-smokers is lower among black males through the 1931 to 1940

Table 8  
Age-specific lung cancer death rates,\* 1950 to 1980, for all males born 1901 through 1940, by birth cohort

Age	1901-1910 Cohort	1911-1920 Cohort	Percent Change	1921-1930 Cohort	Percent Change	1931-1940 Cohort	Percent Change
40-49	17.0	24.0	(41.2)	35.4	(47.5)	33.9	(-4.2)
50-59	91.0	120.1	(31.8)	135.3	(12.7)		
60-69	259.7	306.2	(18.7)				
70-79	470.7						

\* Per 100,000 population.

Table 9  
Age-specific lung cancer death rates,\* 1950 to 1980, for white males born 1901 through 1940, by birth cohort

Age	1901-1910 Cohort	1911-1920 Cohort	Percent Change	1921-1930 Cohort	Percent Change	1931-1940 Cohort	Percent Change
40-49	17.1	22.6	(32.2)	32.7	(44.6)	30.9	(-5.5)
50-59	90.2	115.2	(27.7)	128.4	(11.5)		
60-69	259.9	301.1	(15.8)				
70-79	473.5						

\* Per 100,000 population.

cohort, lung cancer death rates are similar between the races for the 1901 to 1910 cohort, and they are noticeably higher for black males in each successive cohort. For example, for the 1921 to 1930 cohort (Figure 19) in 1985, the lung cancer death rate for black males was more than 36 percent higher than for white males, even though the peak prevalence of smoking among black males in that cohort never achieved that of white males, and the ever-smokers rate matched that of whites only since 1970 (see Figure 18). The reason for this disparity in lung cancer death rates is not clear. Differences in smoking behavior other than prevalence may play a role, such as the type of cigarette smoked and the amount of each cigarette smoked. However, consumption in terms of the number of cigarettes smoked is considerably lower among blacks (US DHHS, 1988).

Table 10

Age-specific lung cancer death rates,\* 1950 to 1980, for nonwhite males born 1901 through 1940, by birth cohort

	1901- 1910 Cohort	1911- 1920 Cohort	Percent Change	1921- 1930 Cohort	Percent Change	1931- 1940 Cohort	Percent Change
Age							
40-49	16.1	36.7	(128.0)	59.0	(60.8)	54.8	(-7.1)
50-59	99.8	166.2	(66.5)	194.7	(17.1)		
60-69	257.8	374.5	(45.3)				
70-79	445.1						

\* Per 100,000 population.

Table 11

Age-specific lung cancer death rates,\* 1950 to 1980, for all females born 1901 through 1940, by birth cohort

	1901- 1910 Cohort	1911- 1920 Cohort	Percent Change	1921- 1930 Cohort	Percent Change	1931- 1940 Cohort	Percent Change
Age							
40-49	3.5	6.1	(74.3)	12.1	(98.4)	16.9	(39.7)
50-59	12.0	30.1	(150.8)	52.1	(73.1)		
60-69	40.0	91.5	(128.8)				
70-79	101.6						

\* Per 100,000 population.

Also to be considered is the shorter life expectancy of black males compared with white males—approximately 8 to 10 years for males born between 1920 and 1950 (Hoffman, 1987). The mortality rate for black males in that age group may result in considerable underestimation of past smoking behavior of the earlier cohorts, more so than for white males, because estimates are based on the behavior of survivors only. Thus, it is possible that there were higher rates of smoking than those reported for those cohorts, resulting in the observed lung cancer mortality rates.

White females (Figures 24, 26, 28, 30, and 32) are similar to white males in that, in later cohorts, there is considerably more initiation of smoking after the peak prevalence than for earlier cohorts, as indicated by differences between the current smoker and ever-smoker curves. For white females, as with

Table 12

Age-specific lung cancer death rates,\* 1950 to 1980, for white females born 1901 through 1940, by birth cohort

	1901- 1910 Cohort	1911- 1920 Cohort	Percent Change	1921- 1930 Cohort	Percent Change	1931- 1940 Cohort	Percent Change
Age							
40-49	3.5	6.0	(71.4)	11.7	(95.0)	16.5	(41.0)
50-59	11.8	30.1	(155.1)	51.6	(71.4)		
60-69	40.5	92.8	(129.1)				
70-79	103.4						

\* Per 100,000 population.

Table 13

Age-specific lung cancer death rates,\* 1950 to 1980, for nonwhite females born 1901 through 1940, by birth cohort

	1901- 1910 Cohort	1911- 1920 Cohort	Percent Change	1921- 1930 Cohort	Percent Change	1931- 1940 Cohort	Percent Change
Age							
40-49	3.6	7.2	(100.0)	14.9	(106.9)	19.5	(30.9)
50-59	13.1	29.7	(126.7)	55.8	(87.9)		
60-69	35.0	79.6	(127.4)				
70-79	83.8						

\* Per 100,000 population.

white males, this becomes apparent for the 1941 to 1950 cohort (Figure 32). The lower overall smoking rates for white females compared with white males for all cohorts shown are borne out in considerably lower lung cancer death rates for women. It can be expected, however, that as later cohorts (e.g., 1951 to 1960) enter the ages at which lung cancer death rates increase rapidly, the lung cancer death rate differential between males and females will begin to disappear because of the narrowing gap in smoking behavior.

Starting with the 1931 to 1940 cohort (Figure 31), the pattern of both current smokers and ever-smokers for black women is similar to that for white women. Prior to 1931 (Figures 25, 27, and 29), black women had lower rates of current smokers and ever-smokers than did white women, with one exception. In the 1921 to 1930 cohort (Figures 28 and 29),

Figure 14  
Changes in current smokers, ever-smokers, and lung cancer deaths, for white U.S. males born 1901 to 1910

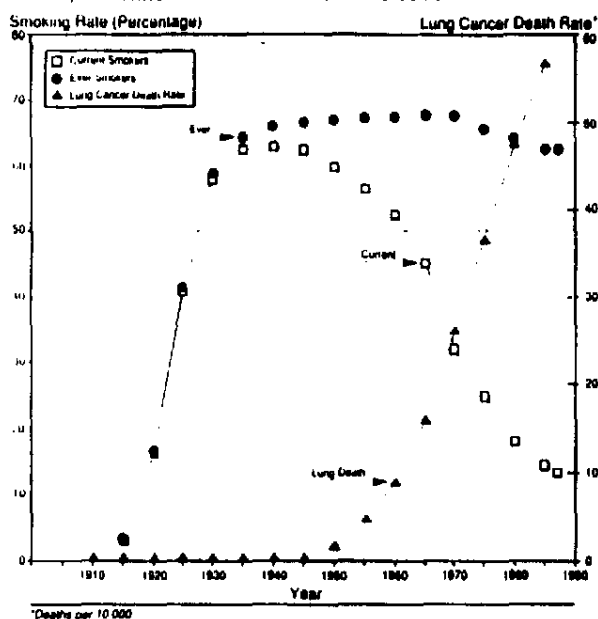
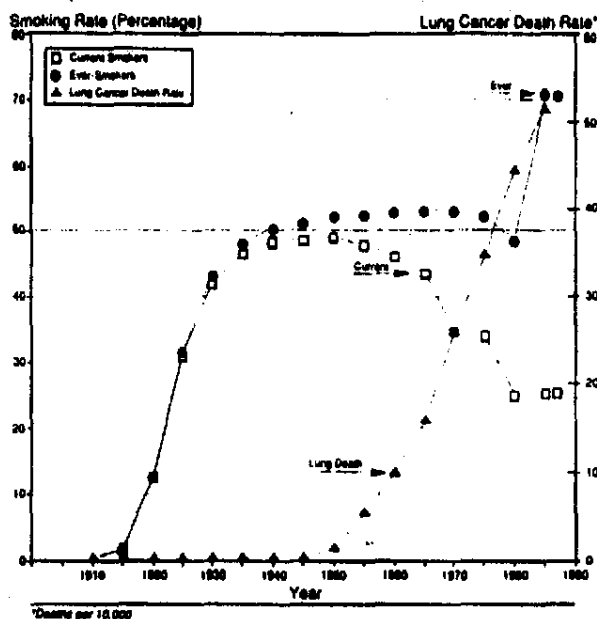


Figure 15  
Changes in current smokers, ever-smokers, and lung cancer deaths, for black U.S. males born 1901 to 1910



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Figure 16  
Changes in current smokers, ever-smokers, and lung cancer deaths, for white U.S. males born 1911 to 1920

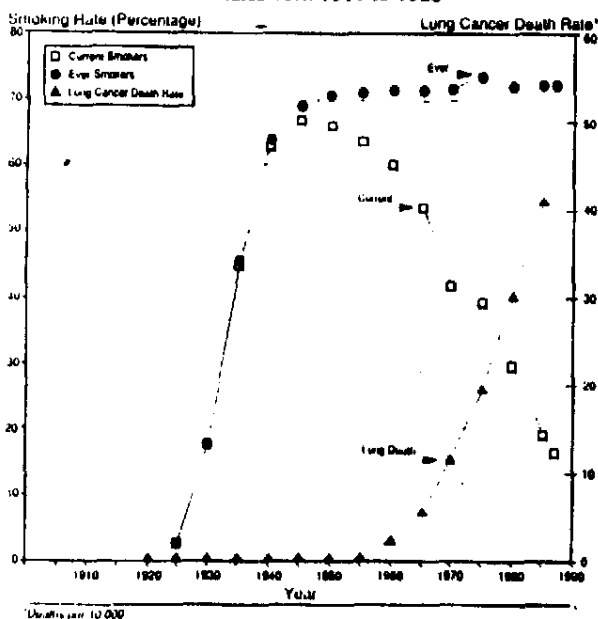
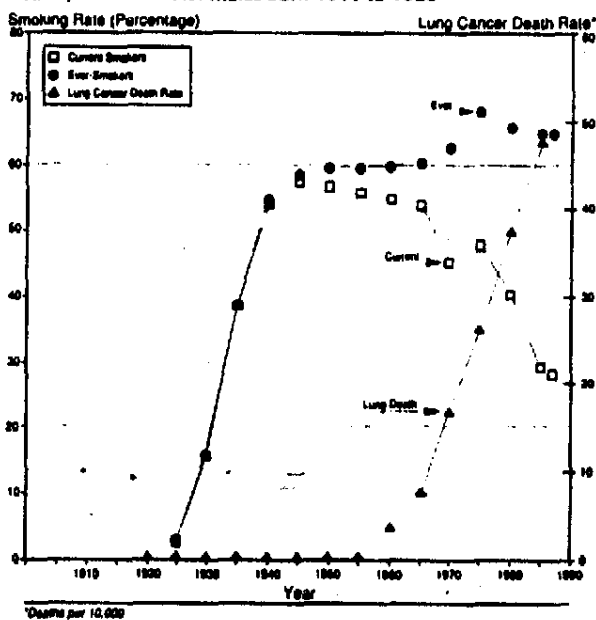


Figure 17  
Changes in current smokers, ever-smokers, and lung cancer deaths, for black U.S. males born 1911 to 1920



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Figure 18  
Changes in current smokers, ever-smokers, and lung cancer deaths, for white U.S. males born 1921 to 1930

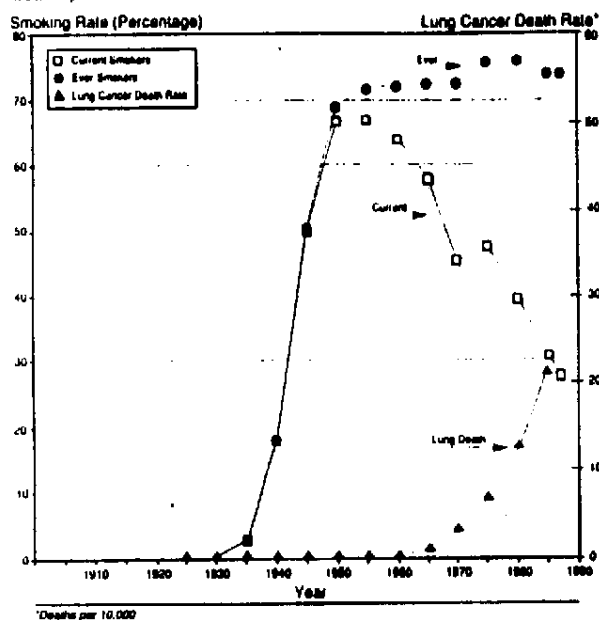
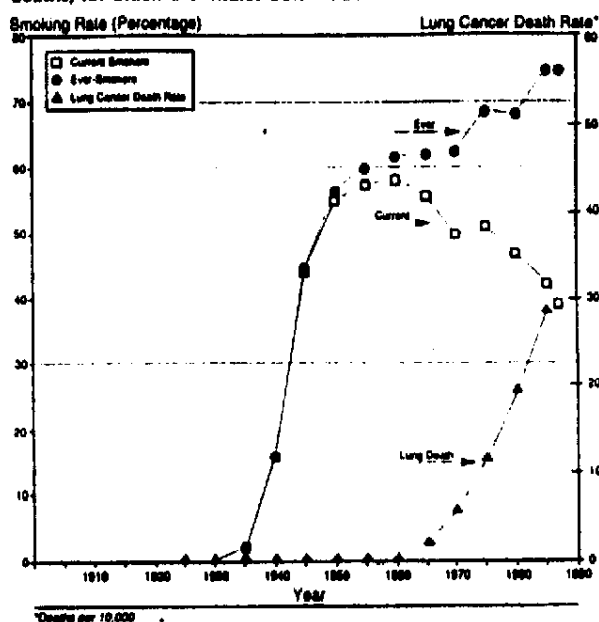


Figure 19  
Changes in current smokers, ever-smokers, and lung cancer deaths, for black U.S. males born 1921 to 1930



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Figure 20  
Changes in current smokers, ever-smokers, and lung cancer deaths, for white U.S. males born 1931 to 1940

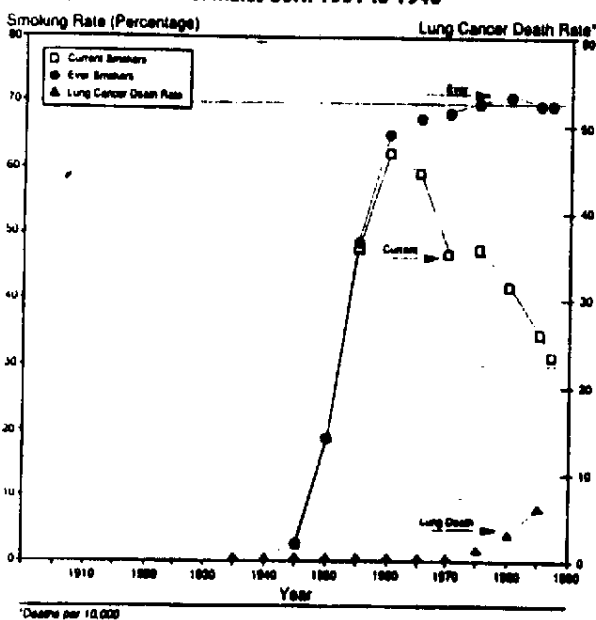
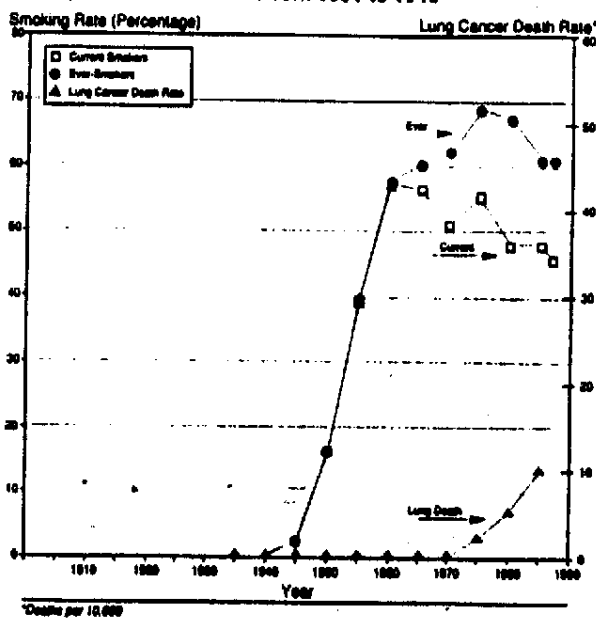


Figure 21  
Changes in current smokers, ever-smokers, and lung cancer deaths, for black U.S. males born 1931 to 1940



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Figure 22  
Changes in current smokers, ever-smokers, and lung cancer deaths, for white U.S. males born 1941 to 1950

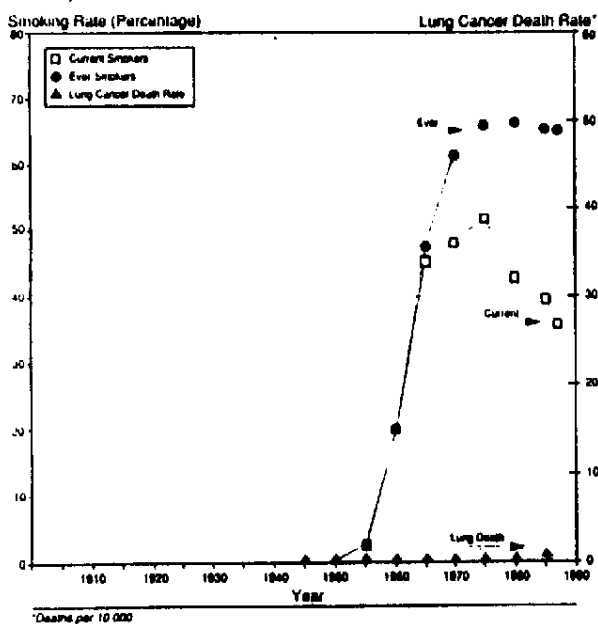
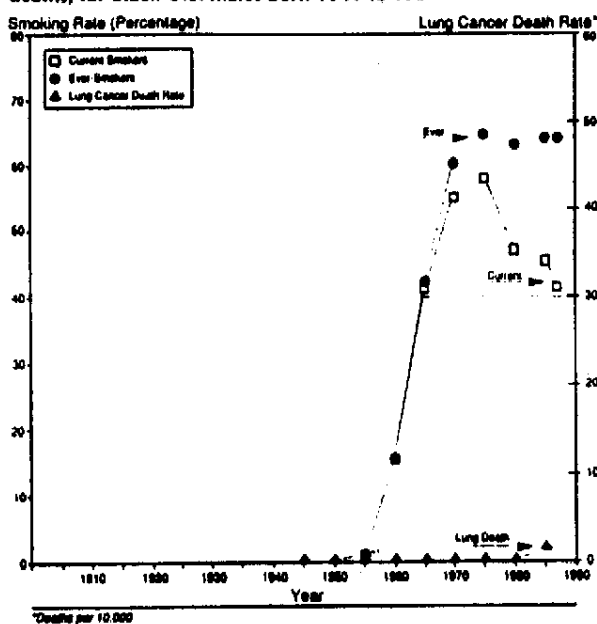


Figure 23  
Changes in current smokers, ever-smokers, and lung cancer deaths, for black U.S. males born 1941 to 1950



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Figure 24  
Changes in current smokers, ever-smokers, and lung cancer deaths, for white U.S. females born 1901 to 1910

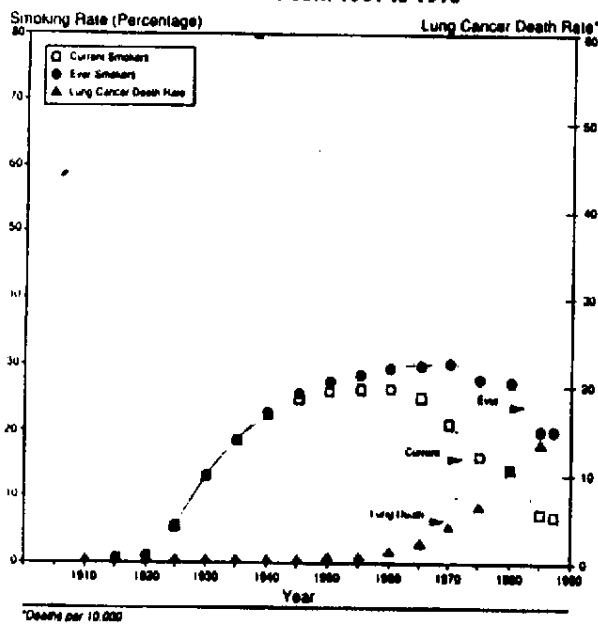
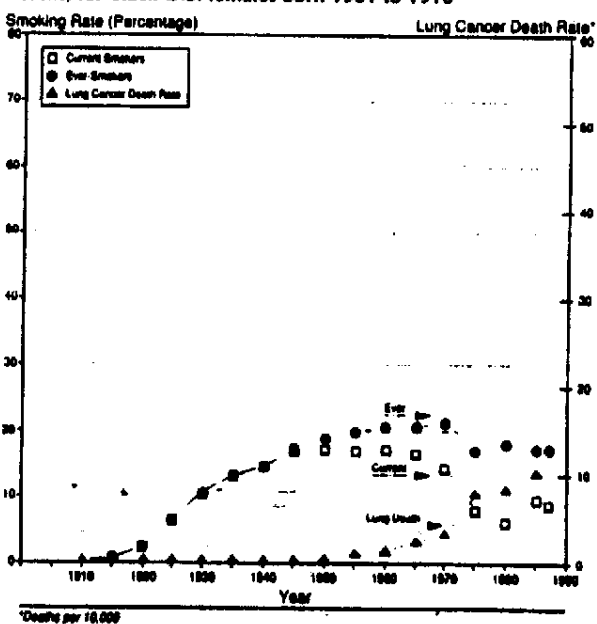


Figure 25  
Changes in current smokers, ever-smokers, and lung cancer deaths, for black U.S. females born 1901 to 1910



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Figure 26  
Changes in current smokers, ever-smokers, and lung cancer deaths, for white U.S. females born 1911 to 1920

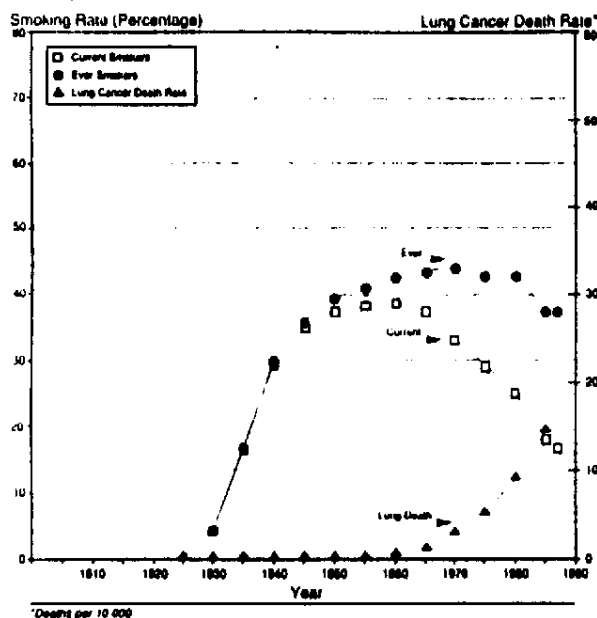
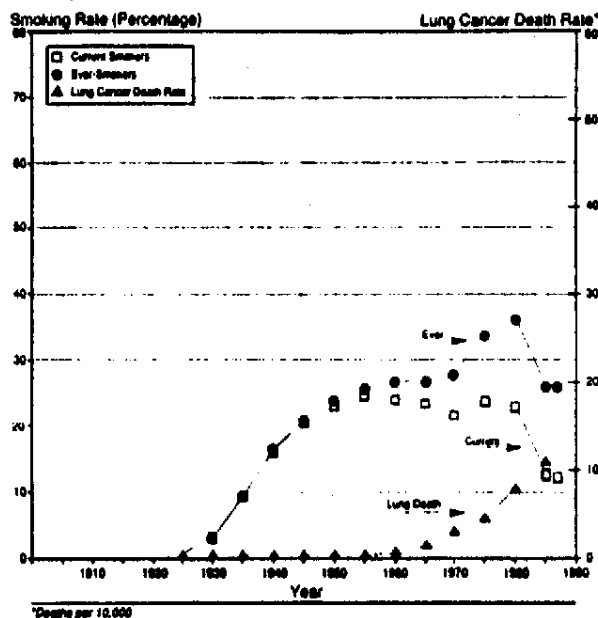


Figure 27  
Changes in current smokers, ever-smokers, and lung cancer deaths, for black U.S. females born 1911 to 1920



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Figure 28  
Changes in current smokers, ever-smokers, and lung cancer deaths, for white U.S. females born 1921 to 1930

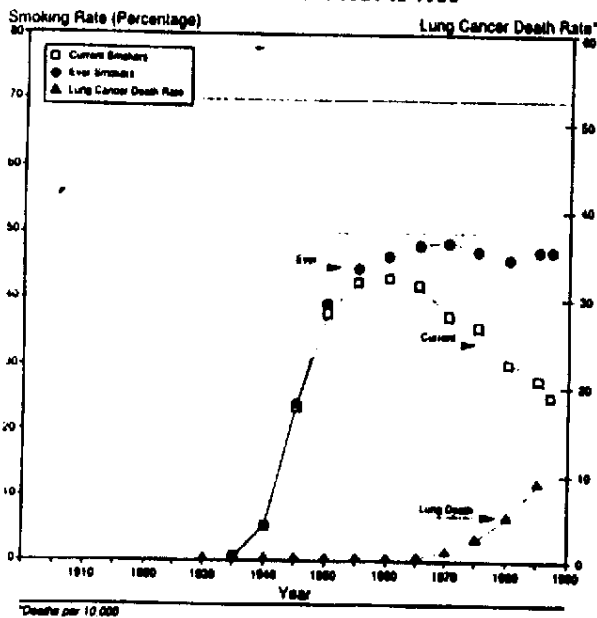
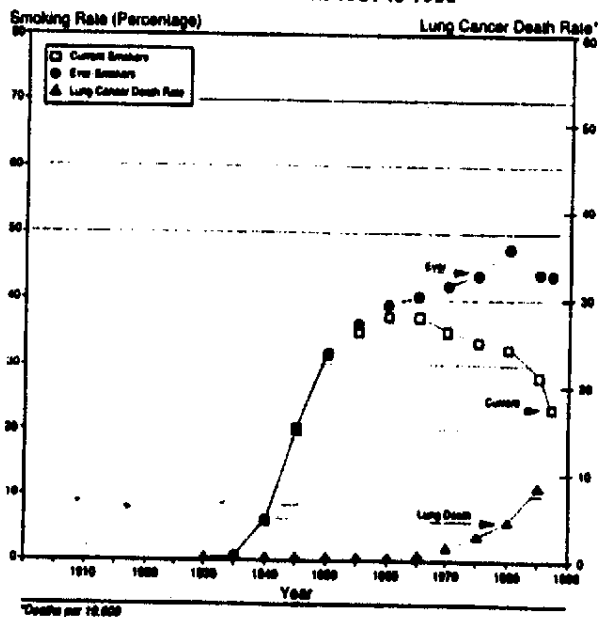


Figure 29  
Changes in current smokers, ever-smokers, and lung cancer deaths, for black U.S. females born 1921 to 1930



Smoking and Tobacco Control Monograph No. 1

51604 5921

Figure 30  
Changes in current smokers, ever-smokers, and lung cancer deaths, for white U.S. females born 1931 to 1940

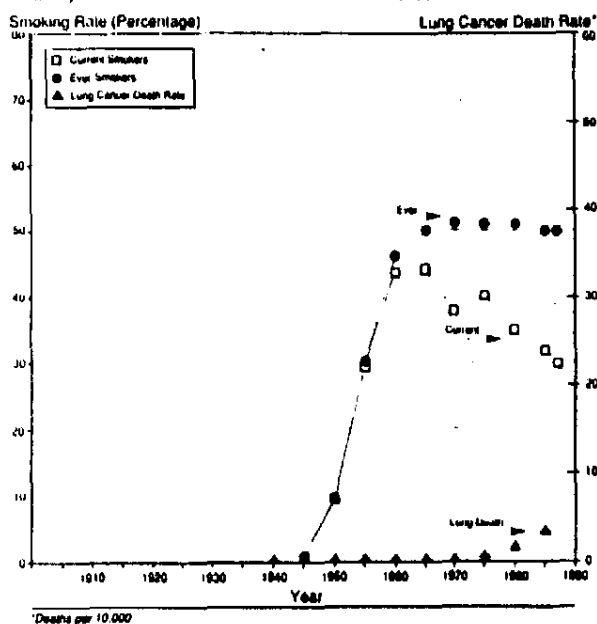
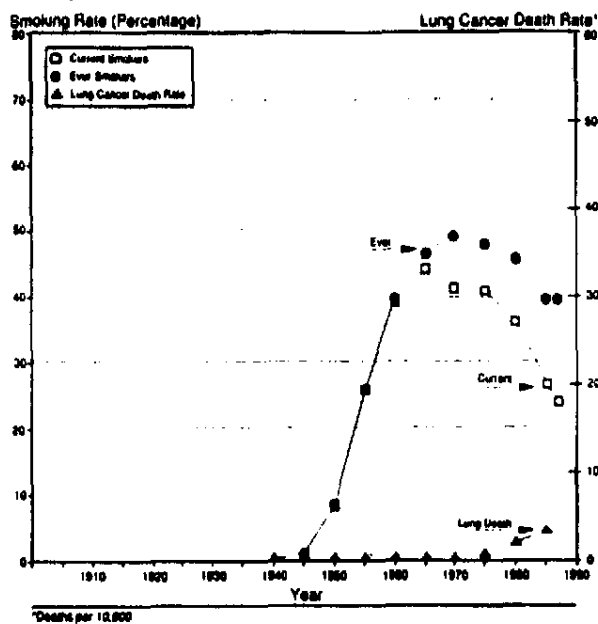


Figure 31  
Changes in current smokers, ever-smokers, and lung cancer deaths, for black U.S. females born 1931 to 1940



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Figure 32  
Changes in current smokers, ever-smokers, and lung cancer deaths, for white U.S. females born 1941 to 1950

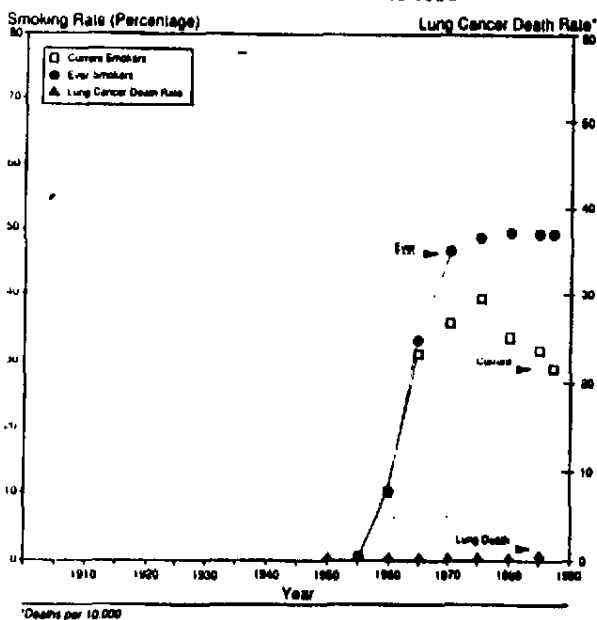
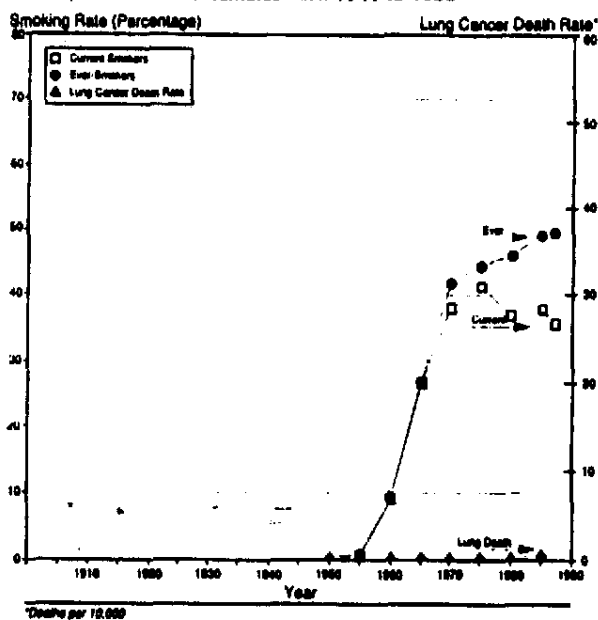


Figure 33  
Changes in current smokers, ever-smokers, and lung cancer deaths, for black U.S. females born 1941 to 1950



Smoking and Tobacco Control Monograph No. 1

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### Use of Birth Cohort Smoking Behaviors To Predict Lung Cancer Death Rates

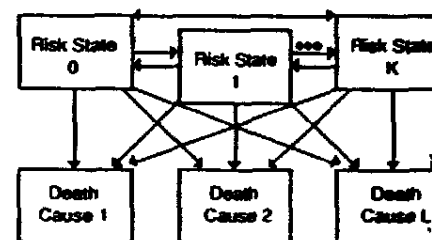
the percentages of ever-smokers reached comparable levels for black women and white women. Lung cancer death rates for all cohorts are approximately the same for white and black females, even though smoking rates are lower for black females in the earliest two cohorts. As smoking rates converged for white and black females in later cohorts, lung cancer death rates remained approximately equivalent for the two races. The equivalent lung cancer rates for white and black females in earlier cohorts, despite lower smoking rates among black females, may again suggest a lung cancer risk that is not attributable to smoking.

Understanding the effects that shifts in the distribution of risk factors (such as smoking patterns) have on disease occurrence and associated health care costs is fundamental to evaluating trends and formulating public policy. In the public policy domain, the determination of which health care programs or projects receive what proportion of limited resources requires analysis of the future costs and benefits of those programs. In assessing health trend effects, changes in either risk factor exposure or the treatment of disease may affect the incidence of disease, the prevalence of chronic conditions, and/or the mortality rates.

The efficacy of a health program in preventing a disease with a long latency period may not be quickly manifest by the usual morbidity and mortality estimates. Primary prevention programs are directed at reducing risk factor exposures, and for many diseases the benefits of altering a risk factor as measured by reductions in mortality or disability require time to emerge. Individuals who already have a disease, including those at preclinical stages, may not benefit from alteration of risk factors and will often continue to progress through the disease course. Thus, intervention studies frequently require 5 to 10 years to show significantly reduced morbidity and mortality risks. During these lengthy periods, the demographic profile of the beneficiary population may shift (e.g., the population may become younger with time) or those with adverse risk factor values may die earlier. In such cases, some of the observed benefits are not the result of interventions but of population shifts in the distribution of risk factors. A health program may reduce the age-specific mortality rates, but this reduction would only partly offset the increase in death rates that accompanies the aging of individuals. Thus, determining the benefits of a risk factor management program requires separating benefits attributable to risk factor modification from benefits attributable to demographic shifts, changes in susceptibility, and mortality selection.

To assess the effects of risk factor interventions on health trends, standard increment-decrement life-table models are generalized to "compartment" models (i.e., discrete state-discrete

Figure 34  
Compartment model schematic of morbidity-mortality process with discrete risk states



time models of health processes) to represent movement between risk factor states. The states in the compartment model can represent death, disability, or an adverse (or beneficial) risk factor status. In the current analysis, the primary risk factor is duration of smoking. Interventions are represented by changes in risk factor states; that is, interventions modify transition rates between certain risk factor and mortality states and change the number of individuals in those states. For example, decreases in the initiation of smoking rates and/or increases in the smoking cessation rates could represent effects of a health intervention in the population. The benefits of this intervention are calculated from incidence and prevalence rates calculated for each compartment and summed across the population.

### A DISCRETE STATE MODEL OF HEALTH INTERVENTION

A compartment model of morbidity-mortality processes is illustrated in Figure 34. An individual resides in only one risk factor state, although he or she can move to any other state at time  $t$ . The risk factor states can represent chronic illness, disability, and risk factor exposure (e.g., smoker versus non-smoker, hypertensive versus not hypertensive). The "well" state is defined as the state with no risk factors. Though an individual can be in only one state at any time, the definitions of states need not be exclusive; e.g., an individual may be in a hypertensive state, a smoking state, or a hypertensive and smoking state. We define the following terms:

- $t$  = time measured in years ( $t = 1, 2, \dots, T$ ).
- $K$  = number of risk factor states (besides the well state). Risk factor: state 0 is the "well" state.



- $L$  = number of causes of death ( $l = 1, 2, \dots, L$ ).  
 $a$  = index for age groups.  
 $n_k(a, t)$  = number of individuals in age group  $a$  at beginning of  $t$  in state  $k$ .  
 $q_{kl}(a, t)$  = probability that a person in age group  $a$  state at  $t$  will die of cause  $l$  during the year.  
 $q_l(a, t)$  = probability that a person in age group  $a$  at  $t$  dies of cause  $l$ ,  
 $= \sum_k q_{kl}(a, t) n_k(a, t) / \sum_k n_k(a, t)$  (1)

### The Markov Assumption

Multiple increment-decrement life tables are special cases of the compartment model seen in Figure 34. Consequently, methods to estimate multiple decrement life-table parameters are easily extended to the compartment model. However, applying those methods for many risk factor states and causes of death requires a huge quantity of data. Problems in evaluating mortality functions arise because (1) all possible pathways that result in the contingent event of interest must be determined, and (2) the probabilities associated with each of these pathways must be assessed. The problems are simplified if the model in Figure 34 can be assumed to be Markovian; i.e., the probability of changing states depends only on the two states (the state the individual is coming from and the state he or she is going to) and not on any previous states the individual has been in or length of time in the current state.

The Markov assumption seems unreasonable, since a person's age and the length of time he or she smoked are determinants of the risks of many causes of death and disease. The Markov assumption can be made more reasonable by defining risk factor states as length of time with a particular risk factor. For example, a person enters the "smoked 0 to 5 years" risk state when smoking begins. In 5 years, the individual moves to a "smoked 5 to 10 years" risk state if he or she still smokes and has not died. Or, the person may enter a "hypertensive and smoked 5 to 10 years" state if the blood pressure rises and he or she continues to smoke. Alternatively, the person who stops smoking may enter the "smoked only 5 years" state. Age can be treated similarly; that is, Figure 34 can be viewed as applicable to a specific age group with risk factor states defined for each subsequent age group. Individuals move between states as they age.

Assuming that the Markov assumption holds for Figure 34, movement between states can be described by a matrix of transition probabilities. If  $\pi_{ij}$  is the probability of moving from state  $i$  to state  $j$  in a year, the transition matrix is

$$\Pi = \begin{pmatrix} \pi_{00} & \pi_{01} & \dots & \pi_{0R} \\ \vdots & \vdots & \ddots & \vdots \\ \pi_{R0} & \pi_{R1} & \dots & \pi_{RR} \end{pmatrix} \quad (2)$$

where the total number of states is  $R + 1 = K + L + 1$ , including the "well" and death states. The  $\pi_{ij}$  are determined from  $n_k(a, t)$  and  $q_{kl}(a, t)$ . To determine the population in each state after  $m$  years, let  $n_i$  be the number of individuals in state  $i$  at time 0. The row vector  $N = (n_0, n_1, \dots, n_R)$  of these counts is called the state vector. The vector  $N^m$  of counts in each state after  $t$  years is

$$N^m = N \Pi^m \quad (3)$$

where  $\Pi^m$  is the product of  $\Pi$  with itself  $t - 1$  times (i.e., the " $t$ " power of  $\Pi$ ). The vector  $N^0, t = 1, 2, \dots$ , is the basis for all discrete survival functions where  $N^0 = (N_0(t), N_1(t), \dots, N_R(t))$ . The model is useful for forecasting future contingent outcomes and evaluating functions associated with morbidity and mortality outcomes under various interventions or changes in the population.

Because the current model is more biologically plausible than simply "alive-dead" and "standard-substandard risk" classifications, forecast estimates will be more accurate. By selecting a sufficient number of risk factor and mortality states, one can model any finite combination of risk factors. A model representing the interactions of risk factors and chronic conditions is more defensible than risk scoring methods that do not represent those interactions (see Cummins et al., 1983). In this chapter, the above model is used to forecast lung cancer mortality patterns.

### Previous Forecast Methods

Several researchers have presented models for forecasting mortality patterns for lung cancer. The simplest method is to assume that the age-specific mortality rates will remain constant and then predict the number of deaths in the future from the number of individuals expected in each age group. A sophisticated version of this model is given by Brown and Kessler (1988), in which the differential cohort effects and differential smoking patterns are included in estimating the age-specific lung cancer mortality rate. The Brown and Kessler model also used the number of cigarettes and the tar per cigarette as regressor variables for the period effects. The model does not explicitly include the length of time that people smoked. Forecasts are based on estimated effects of cohort, age, smoking status, and "dose" (as measured by two variables, average cigarettes and tar levels). The model adjusts for smoking duration and for any competing risks of deaths only

implicitly; that is, insofar as these two variables are reflected in the mortality risks of lung cancer in the observed data used to fit the model, this same relationship is maintained in the forecasting formula.

Hakulinen and Pukkala (1981) use a similar method but make explicit adjustments for subjects' length of smoking and time since they last smoked. Although this model is more sophisticated in the use of smoking duration, it does not estimate the cohort effects from observed lung cancer mortality over time as the Brown and Kessler model does. The model also adjusts for the competing risks implicitly, by assuming that the mortality risks used contained the appropriate adjustment.

The model proposed in this chapter extends these models in two ways. First, explicit adjustment of the competing risks is taken into account. Because current and past smoking patterns have a differential effect on both lung cancer and other competing risks, forecasting the effects of changes in the smoking patterns over the last 10 years and the anticipated smoking patterns on future lung cancer mortality requires "unbundling" the different mortality risks. Second, the model uses the mortality risk explicitly as a function of smoking initiation and cessation rates in a Markov model. Explicit identification of these components provides the forecaster more freedom in altering the constituent parts of the model to examine the long-term effects of interventions and health promotion programs on mortality outcome. As in the models described above, the current model does provide a cohort-specific, smoking-duration-based model. However, rather than examine the trends of the mortality risks over the last two decades, as Brown and Kessler have done, this model assumes that the underlying causes of these trends are represented by the risk factor and population dynamics used in the model.

To build a model, estimates of the transition probabilities are required. Tolley and Manton (in press) have described how the various types of health statistics can be used to determine estimates. In this section, the estimation of these transition probabilities is briefly described, and the data sources for making the estimates are presented.

The first step in the estimation is to determine the number of individuals in each of the risk factor states. Naturally, the primary risk factor state here is smoking status: whether or not the individual is or has been a smoker and, if a smoker, the duration of smoking. The initiation and cessation rates over time for birth cohorts of black and white males and females can be estimated from the NHIS data presented in the first part of this chapter. From these estimates, estimates of the number of individuals who are current smokers with a smoking

duration of 5 years, 10 years, and so forth, can be obtained for both races and sexes for the entire Nation. In addition, estimates of the number of individuals who have never smoked, and the number of ex-smokers who smoked 5 years, 10 years, and so on, can be obtained. All of these estimates of smoking duration are specific to various birth cohorts beginning with the 1901 to 1910 cohort and including birth cohorts up to the 1951 to 1960 cohort.

Table 14 gives the distribution of each cohort in terms of their current smoking status in 1980. Naturally, these three smoking states can be subdivided. For the current model, the risk factor states for smoking are "never smoked," "current smoker" (divided into 5-year duration intervals up to "smoked over 70 years"), and "ex-smoker," which also is divided into 5-year duration intervals. This gives 31 smoking states.

The data given in the first section of this chapter show different patterns of initiation and cessation in various birth cohorts; therefore, the model here is developed through separate treatment of each of the 10-year birth cohorts. The oldest cohort considered in this study is the 1901 to 1910 cohort, and the youngest is the 1951 to 1960 cohort.

Although risk factors such as hypertension, elevated blood cholesterol, alcohol consumption, and obesity are also important in the assessment of the future mortality patterns, current data on these patterns and how these patterns are expected to change in the future are limited. Therefore, these risk factors are disregarded in the current model, reflecting an assumption that, whatever the current patterns are, they will remain unchanged in the next three decades.

The reason for including causes of death other than lung cancer is to adjust for their competing effects. Those causes of death that have smoking as a major risk factor must be considered as separate states in the model. Changes in smoking patterns will then be adjusted for in each such competing risk. All causes of death that do not have smoking as a primary risk factor can be grouped together as a "death by all other causes" state. Table 15 lists all causes other than lung cancer that are assumed (in this model) to have smoking as a major risk factor.

The second step is to determine the relative risk associated with each risk factor level. For all causes of death except lung cancer, this model assumes that the relative risk is independent of the length of time that subjects smoked. Models relating smoking duration to coronary heart disease death and chronic obstructive pulmonary disease death are less established; therefore, they have not been included. Relative risks for current smokers and ex-smokers, both males and females, have been given in the Surgeon General's Report (US DHHS, 1989).

## Building the Model

### The Risk Factor States

### Causes of Death

### Relative Risks

Table 14  
Distribution of nonsmokers, smokers, and ex-smokers in 1980,  
by race, gender, and birth cohort

	Never-Smokers	Current Smokers	Ex-Smokers
Born 1901-1910			
White male	.36	.19	.45
White female	.72	.15	.13
Black male	.52	.22	.26
Black female	.82	.06	.12
Born 1911-1920			
White male	.28	.30	.42
White female	.57	.26	.17
Black male	.34	.40	.26
Black female	.64	.23	.13
Born 1921-1930			
White male	.24	.40	.36
White female	.54	.31	.15
Black male	.32	.47	.21
Black female	.52	.34	.14
Born 1931-1940			
White male	.29	.42	.29
White female	.49	.35	.16
Black male	.33	.49	.18
Black female	.54	.36	.10
Born 1941-1950			
White male	.34	.43	.23
White female	.50	.34	.16
Black male	.37	.47	.16
Black female	.54	.37	.07
Born 1951-1960			
White male	.49	.39	.12
White female	.56	.33	.11
Black male	.46	.45	.09
Black female	.62	.33	.05

Estimates of relative risks, reproduced in Tables 15 and 16, are used here. Note that since these risks are not race-specific, the same relative risks are used for both blacks and whites.

Table 15  
Relative risks of death for current and former smokers (males)

	ICD Code <sup>a</sup>	Age	Current Smokers	Former Smokers
Cause of Death <sup>b</sup>				
CHD	(410-414)	35 - 64	2.81	1.75
		65+	1.82	1.29
Other heart	(390-398, 401-405)		1.85	1.32
CVD	(430-438)	35 - 64	3.67	1.38
		65+	1.94	1.27
Other vascular	(440-448)		4.08	2.33
COPD	(490-492, 496)		9.65	8.75
Other pulmonary	(010-012, 480-489, 493)		1.99	1.56
Oral cancers	(140-149)		27.48	8.80
Bladder cancer	(188)		2.88	1.10
Kidney cancer	(189)		2.95	1.95
Pancreatic cancer	(157)		2.14	1.12
Esophageal cancer	(150)		7.60	5.83

<sup>a</sup>ICD, International Classification of Diseases.

<sup>b</sup>CHD, coronary heart disease; CVD, cardiovascular disease; COPD, chronic obstructive pulmonary disease.

Several authors have posited models relating the mortality from lung cancer to age and duration of smoking. Peto (1986) proposed a model that related smoking duration to risk of lung cancer. Peto's model included smoking dose in two ways: first, there is a specific model for heavy smokers and moderate smokers; second, the cumulative dose, as measured by smoking duration, is explicitly included in determination of the risk. The models by Gaffney and Altshuler (1988) and those by Moolgavkar et. al (1989) are more sophisticated in their use of dose in determining relative risks of lung cancer instantiation. Although this second set of dose-related models seems to offer many strengths, the data available from the NHIS set sample provide good information on duration of smoking only and not explicitly on dose.

Because of data limitations, the model used here for determining risk of lung cancer is that given by Peto. The probability of death by lung cancer for a person aged "a" who has smoked for "y" years is given by

$$\text{Prob (of death by lung cancer)} = 10^{-11}a^4 + 10^{-7}y^4.$$

Table 16  
Relative risks of death for current and former smokers (females)

	ICD Code*	Age	Current Smokers	Former Smokers
Cause of Death*				
CHD	(410-414)	35 - 64	3.00	1.43
		65+	1.80	1.29
Other heart	(390-398, 401-405)		1.89	1.16
CVD	(430-438)	35 - 64	4.80	1.41
		65+	1.47	1.01
Other vascular	(440-448)		3.00	1.34
COPD	(490-492, 496)		10.47	7.04
Other pulmonary	(010-012, 480-489, 493)		2.18	1.38
Oral cancers	(140-149)		5.59	2.88
Bladder cancer	(188)		2.58	1.85
Kidney cancer	(189)		1.41	1.16
Pancreatic cancer	(157)		2.33	1.78
Esophageal cancer	(150)		10.25	3.18

\*ICD, International Classification of Disease.

\*CHD, coronary heart disease; CVD, cardiovascular disease; COPD, chronic obstructive pulmonary disease.

Before using the Peto model, we must modify it for several reasons: First, the aggregation of moderate and heavy smokers into the same group, necessitated by the NHIS data format, is problematic; we expect that the "average" probability of lung cancer death would be higher than predicted by the model. Second, since the model was derived from a subpopulation of smokers in Britain, the toxicity of the smoked material and the method of smoking may differ from those characteristics in the United States. Third, the more prevalent use of filters on cigarettes in the last two decades may cause the model to estimate incorrectly the likelihood of death for more recent birth cohorts.

The adjustment of the Peto model is as follows: We assume that for each gender- and race-specific birth cohort, the model for the probability of lung cancer can be determined from the Peto model by a scaling equation (4) as follows:

$$\begin{aligned} \text{Prob}(\text{of death by lung cancer for nonsmoker}) &= 510^{-11}a^4 \\ \text{Prob}(\text{of death by lung cancer for a current smoker}) &= 510^{-11}a^4 + 510^{-4}y^4 \\ \text{Prob}(\text{of death by lung cancer for a former smoker}) &= 510^{-11}a^4 + 5510^{-9}y^4 \end{aligned}$$

#### Calculating Transition Probabilities

In these equations, the unknown parameter  $S$  is a scale parameter. This parameter is determined by calculation of the observed number of deaths by lung cancer in 1980 for each birth cohort-gender-race combination, and comparison to the number predicted from the above equations. The value of  $S$  for each cohort-gender-race combination is the value that equates the predicted with the observed number of deaths.

The probability of transitioning to one of the cause-of-death states (except death by lung cancer) from the never-smoked state for a particular age group is given by the following equation:

$$q_m(a,0) = \frac{[\text{Number of observed deaths from cause } i]}{[n_0(a,0) + R1_n n_{1n}(a,0) + R2_n n_{2n}(a,0)]}$$

In this equation,  $R1$  is the relative risk of the current smokers for the particular cause of death, and  $R2$  is the relative risk of the ex-smokers for the same cause of death. The indexes  $k_1$  and  $k_2$  refer to current smoker and ex-smoker states, respectively. The transition probabilities for the particular cause of death for current smokers and ex-smokers are given by

$$q_{1i}(a,0) = R1 q_{mi}(a,0)$$

$$q_{2i}(a,0) = R2 q_{mi}(a,0)$$

Calculation of the probability of transition from the "never-smoked" state to death by lung cancer is calculated similarly; however, in this case, each of the smoking levels has a different relative risk, as calculated by the modified Peto model (above).

The transition probabilities for transitioning from the "never-smoked" to the "smoked-5-years-or-less" state are determined from the past initiation patterns. These probabilities are assumed to be age-dependent and cohort-dependent; however, because forecasting what pattern the younger cohorts will follow in the future is difficult, a single table for all cohorts for future initiation as a function of age was estimated. Table 17 is estimated from the initiation rates of the older cohorts and gives the estimated initiation rates, by age group. How current awareness of the detrimental effects of smoking will reduce these initiation rates can only be guessed.

Future cessation patterns, like future initiation patterns, are affected by the recent health trends in the United States. The estimated cessation rates, as a function of duration of smoking, are given in Table 18. These rates are determined by the experience of older cohorts and modified by recent trends toward better health.

Table 17  
Probability of initiating smoking in future as a function of age  
(5-year rate)

	White Male	White Female	Black Male	Black Female
Age Group				
20 - 24 years	.20	.05	.16	.09
25 - 29	.37	.20	.30	.18
30 - 34	.30	.17	.25	.20
35 - 39	.10	.08	.10	.08
40 - 44	.03	.05	.05	.07
45 - 49	.02	.03	.04	.05
50 - 54	.01	.015	.02	.03
55 - 59	.01	.015	.01	.01
60 - 64	.005	.005	.005	.01
65 +	0	0	0	0

Table 18  
Probability of termination of smoking during 5-year period,  
by 5-year duration

	White Male	White Female	Black Male	Black Female
Duration of Smoking				
< 5 years	.05	.05	.05	.06
5 - 10	.08	.10	.08	.07
10 - 15	.10	.10	.08	.06
15 - 20	.10	.08	.06	.05
20 - 25	.10	.10	.05	.04
25 - 30	.15	.08	.05	.04
30 - 35	.15	.05	.04	.03
35 - 40	.10	.05	.03	.03
40 - 45	.05	.05	.03	.03
45 +	.05	.05	.03	.03

#### Results and Forecasts

The parameters estimated above can now be placed in the model described previously, to forecast mortality outcomes for each race and gender. These forecasts are summarized in Tables 19 through 22 for each race and gender combination. Entries in the tables are the age-specific annual mortality rates per 100,000 individuals.

Examining the values in these tables, we see several important points. One point of interest is that, for white males and white females, the age-specific lung cancer mortality rate drops

Table 19  
Forecast mortality rates\* for select causes of death, white males,  
ages 55 to 84

	Lung Cancer	Other Cancers	Coronary Heart Disease	All Other Causes
Year				
	Age group 55 - 64			
1980	208.76	78.98	585.48	858.48
1985	181.34	81.56	602.48	873.19
1995	100.69	74.88	583.55	854.46
2005	26.91	70.82	536.02	831.36
2015	14.97	77.45	578.38	856.19
	Age group 65 - 74			
1980	375.79	182.06	1,384.57	2,086.08
1985	385.37	189.00	1,412.82	2,124.37
1995	321.03	175.53	1,443.87	2,163.87
2005	178.88	162.94	1,399.21	2,115.58
2015	49.13	155.46	1,357.07	2,056.93
	Age group 75 - 84			
1980	478.60	242.20	2,554.47	4,169.47
1985	508.34	393.92	3,246.97	5,986.54
1995	516.52	429.99	3,350.83	6,192.03
2005	451.04	458.14	3,440.06	6,403.72
2015	254.08	421.78	3,348.47	6,195.09

\* Deaths per 100,000; 1980 data are actual, not forecast.

rather quickly for the younger age groups because of the low peak prevalence rates in more recent cohorts. For older age groups, this reduction occurs much more slowly. Note that the forecast model begins with the actual data for 1980; however, the values for 1985 and subsequent years are predicted from 1980 mortality rates combined with the estimated smoking rates and the relative risks—as calculated with the Peto model.

Although the mortality risks from coronary heart disease and from cancers other than lung are notably higher for smokers, as evidenced in Tables 15 and 16, the observed mortality rates for these causes are forecast to change very little over the next 25 years. One reason for this is that the age-specific mortality rates for different years are determined by the experience of different birth cohorts. Although the age-specific mortality rate for the "never-smoked" individuals is constant over time, the percentage of the population in each smoking state differs for each cohort. As a consequence, the number of individuals who are current smokers and ex-smokers and the

Table 20  
Forecast mortality rates\* for select causes of death, white females,  
ages 55 to 84

Year	Lung Cancer	Other Cancers	Coronary Heart Disease	All Other Causes
Age group 55 - 64				
1980	71.29	34.62	177.87	591.89
1985	77.62	35.74	185.10	601.68
1995	67.28	36.53	186.19	600.72
2005	30.57	35.82	178.18	588.91
2015	14.80	38.80	193.10	605.65
Age group 65 - 74				
1980	98.11	70.75	597.32	1,293.86
1985	126.22	76.04	623.35	1,324.53
1995	150.88	78.17	637.81	1,343.84
2005	130.33	80.32	640.43	1,341.47
2015	60.00	79.60	624.12	1,313.48
Age group 75 - 84				
1980	104.40	106.11	1,410.84	2,571.00
1985	128.22	140.30	1,972.20	3,465.08
1995	199.74	160.30	2,096.18	3,619.20
2005	239.28	165.62	2,145.72	3,688.71
2015	208.90	170.37	2,155.74	3,681.28

\* Deaths per 100,000; 1980 data are actual, not forecast.

number in each duration state are different. Differential effects of lung cancer as a competing risk and the differences in the number of smokers both will alter the mortality rates for these other causes.

The forecast of the overall lung cancer rate is given in Table 23, where the age-standardized rate per 100,000 population between the ages of 55 and 84 is given for each of the four general causes of death. The rates in this table are substantially higher than the overall age-adjusted death rates because they are only for those between the ages of 55 and 84 rather than being age-standardized for the entire population. The population used for age standardization is the 1980 U.S. population. Note that although the lung cancer mortality rate for white males is forecast to increase through 2005 for older ages and decrease for younger ages, the age-standardized rate is forecast to decrease. However this decrease is relatively slower than age-specific decreases in younger ages, being almost constant

Table 21  
Forecast mortality rates\* for select causes of death, black males,  
ages 55 to 84

Year	Lung Cancer	Other Cancers	Coronary Heart Disease	All Other Causes
Age group 55 - 64				
1980	314.75	168.86	588.33	1,794.73
1985	328.73	170.68	597.34	1,810.84
1995	259.30	165.37	580.68	1,790.37
2005	113.31	162.05	584.10	1,756.58
2015	95.30	176.18	601.21	1,783.03
Age group 65 - 74				
1980	452.74	224.42	1,195.15	3,244.89
1985	554.03	242.24	1,232.01	3,309.03
1995	600.65	244.18	1,238.17	3,325.57
2005	473.81	238.98	1,221.15	3,289.84
2015	215.75	233.29	1,202.22	3,228.78
Age group 75 - 84				
1980	488.59	239.95	1,958.85	5,408.63
1985	523.15	394.34	2,438.00	6,794.00
1995	759.31	471.70	2,575.20	7,104.08
2005	823.01	475.54	2,589.97	7,142.38
2015	652.22	458.10	2,559.84	7,062.83

\* Deaths per 100,000; 1980 data are actual, not forecast.

until 1995. For all other gender-race combinations, the age-standardized lung cancer mortality rates increase until around 2000 and then decrease. Thus, the decreases in smoking patterns that have occurred prior to the current time will have little effect on decreasing age-standardized rates until 2005 for all but white males.

#### Potential Reduction in Lung Cancer

The mortality rates forecast by the model assume that current patterns of initiation and cessation will continue over the next 25 years. The impact of improved smoking control strategies can be estimated with this model. If one assumes that implementation of the comprehensive smoking control strategies described in this volume would double current rates of cessation, then the impact of these improvements can be calculated, as presented in Table 24. The lung cancer mortality estimates in Table 24 can be compared with those in the first columns of Tables 19 through 22.

Table 22  
Forecast mortality rates\* for select causes of death, black females,  
ages 55 to 84

Year	Lung Cancer	Other Cancers	Coronary Heart Disease	All Other Causes
Age group 55 - 84				
1980	73.32	62.40	315.95	1,102.76
1985	94.79	67.65	339.88	1,128.58
1995	95.99	68.35	343.61	1,129.22
2005	38.66	70.55	349.36	1,125.35
2015	45.73	76.99	378.51	1,155.40
Age group 65 - 74				
1980	85.69	99.60	729.56	2,140.22
1985	115.24	115.82	779.26	2,217.30
1995	183.92	127.46	808.21	2,238.60
2005	186.36	128.32	807.08	2,239.14
2015	77.84	132.42	808.50	2,217.33
Age group 75 - 84				
1980	86.81	127.68	1,381.49	3,657.17
1985	96.44	150.15	1,759.85	4,449.39
1995	178.13	185.61	1,916.42	4,871.24
2005	288.34	203.44	1,974.39	4,722.32
2015	292.83	205.21	1,977.33	4,727.77

\*Deaths per 100,000; 1980 data are actual, not forecast.

For white males, there is a dramatic change in the predicted lung cancer mortality pattern, with approximately a 50 percent reduction in age-specific lung cancer death rates for all age groups by the year 2015. It is important that this reduction is in addition to the benefits to be expected from current smoking control efforts.

The results for the other racial and gender groups are more modest but still impressive. The more modest reductions reflect the lower current rates of cessation in those groups and, therefore, dramatically underestimate the benefits that could be achieved if the cessation patterns occurring among white males can be replicated in the other racial and gender groups.

- Males born early in this century became cigarette smokers earlier in life and in greater percentages than females. The pattern of initiation and peak prevalence of smoking is similar for males and females born into the most recent birth cohorts.

## CONCLUSIONS

Table 23  
Forecast age-standardized mortality rates,\* based on 1980  
population

Year	Lung Cancer	Other Cancers	Coronary Heart Disease	Other Causes
White male				
1980	310.6154	134.8752	1,192.714	1,841.914
1985	305.7283	164.9100	1,331.280	2,174.659
1995	245.9573	170.0526	1,340.338	2,217.751
2005	150.9946	168.6918	1,327.521	2,227.296
2015	67.95557	163.2606	1,318.622	2,183.843
White female				
1980	88.18845	83.94307	616.8047	1,305.564
1985	105.5484	74.50172	765.1822	1,537.834
1995	127.0899	80.41854	800.6575	1,581.471
2005	114.2955	82.12020	810.1826	1,592.848
2015	77.01571	84.31486	813.6352	1,588.735
Black male				
1980	389.3818	198.0883	1,016.176	2,874.051
1985	435.8217	231.4099	1,112.363	3,131.886
1995	455.4529	242.1545	1,128.678	3,178.280
2005	350.4382	238.7241	1,117.134	3,155.673
2015	227.2963	241.7119	1,124.481	3,139.918
Black female				
1980	80.22296	88.16579	671.2568	1,970.012
1985	102.0179	100.6025	775.6823	2,187.45
1995	142.2724	112.0328	818.2055	2,229.809
2005	139.0348	118.9478	832.8903	2,229.558
2015	108.6173	121.6528	946.4619	2,237.143

\*Deaths per 100,000; 1980 data are actual, not forecast.

- White males began to quit smoking in substantial numbers during the 1950's, but black males, white females, and black females did not begin to quit in substantial numbers until the late 1960's.
- In general, the birth cohort pattern of cigarette smoking closely matches the pattern of lung cancer death rates within each racial and gender grouping, but black males and females appear to have higher rates of lung cancer than white males and females, even after consideration of the differences in their smoking behaviors.

Table 24  
Forecast age-specific lung cancer mortality rates,\* assuming  
cessation rates are doubled

Year	White Male	White Female	Black Male	Black Female
Age group 55 - 64				
1980	208.76	71.29	314.78	73.32
1985	170.67	75.04	321.54	92.62
1995	73.49	57.46	235.19	88.38
2005	15.49	21.60	91.20	32.29
2015	7.30	8.58	65.24	33.28
Age group 65 - 74				
1980	375.79	98.11	452.74	85.89
1985	378.39	122.73	544.93	113.27
1995	276.21	134.41	559.70	171.67
2005	115.14	101.44	404.11	162.25
2015	24.66	38.41	162.14	61.03
Age group 75 - 84				
1980	478.60	104.40	488.59	86.81
1985	502.75	123.99	517.38	95.38
1995	485.26	185.24	721.70	168.96
2005	364.44	201.04	732.67	257.39
2015	150.83	152.14	525.41	242.49

\*Deaths per 100,000; 1980 data are actual, not forecast.

- A model of future lung cancer death rates based on trends in smoking behavior presented in this chapter predicts that the lung cancer death rates for white males will begin to fall by 1995, with declines in lung cancer death rates occurring later among the other racial and gender groups.
- A doubling of the effectiveness of current smoking control programs could result, by the year 2015, in up to a 50 percent reduction in lung cancer death rates from those that will occur if current trends continue.

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## Appendix A

## Data Points for Figures in Chapter 3

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Figure 1. U.S. per capita cigarette consumption for adults, aged 18 and older (1900 to 1990)

Year	Per Capita	Year	Per Capita
1900	54	1945	3,448
1901	53	1946	3,446
1902	60	1947	3,416
1903	64	1948	3,505
1904	66	1949	3,460
1905	70	1950	3,522
1906	86	1951	3,744
1907	98	1952	3,886
1908	105	1953	3,778
1909	125	1954	3,546
1910	151	1955	3,597
1911	173	1956	3,650
1912	223	1957	3,755
1913	280	1958	3,953
1914	267	1959	4,073
1915	285	1960	4,171
1916	305	1961	4,266
1917	551	1962	4,265
1918	687	1963	4,345
1919	727	1964	4,185
1920	665	1965	4,259
1921	742	1966	4,287
1922	770	1967	4,260
1923	911	1968	4,186
1924	902	1969	3,983
1925	1,085	1970	3,985
1926	1,191	1971	4,037
1927	1,279	1972	4,043
1928	1,366	1973	4,148
1929	1,504	1974	4,141
1930	1,485	1975	4,123
1931	1,388	1976	4,082
1932	1,245	1977	4,051
1933	1,334	1978	3,967
1934	1,463	1979	3,861
1935	1,564	1980	3,851
1936	1,754	1981	3,840
1937	1,847	1982	3,753
1938	1,830	1983	3,502
1939	1,900	1984	3,461
1940	1,976	1985	3,370
1941	2,236	1986	3,274
1942	2,585	1987	3,197
1943	2,956	1988	3,096
1944	3,039	1989	2,926
		1990	2,828

Figure 2. Changes in prevalence of cigarette smoking among successive birth cohorts of U.S. males, 1900 to 1987

X Data	1901-1910	1911-1920	1921-1930	1931-1940	1941-1950	1951-1960	1961-1970
1900	0	0	0	0	0	0	0
1905	0	0	0	0	0	0	0
1910	0.4	0	0	0	0	0	0
1915	2.9	0	0	0	0	0	0
1920	16.2	0.2	0	0	0	0	0
1925	39.9	2.6	0	0	0	0	0
1930	58.7	17.4	0.4	0	0	0	0
1935	61.3	44.3	2.8	0	0	0	0
1940	61.8	62.0	17.8	0.3	0	0	0
1945	61.3	65.9	49.4	2.6	0	0	0
1950	58.9	65.2	65.8	18.7	0.1	0	0
1955	55.8	62.6	66.1	47.0	2.3	0	0
1960	51.8	59.6	63.5	61.8	19.1	0.2	0
1965	45.0	53.6	57.7	59.0	44.7	2.6	0
1970	32.0	42.1	45.9	47.4	48.5	17.7	0.3
1975	25.4	38.8	48.1	48.1	52.3	39.4	3.7
1980	18.6	30.5	40.3	42.5	43.3	39.6	18.7
1985	15.3	19.8	32.5	35.7	39.5	36.1	32.4
1987	14.3	17.3	29.5	32.3	35.7	32.1	30.0

Figure 3. Changes in prevalence of cigarette smoking among successive birth cohorts of U.S. females, 1900 to 1987

X Data	1901-1910	1911-1920	1921-1930	1931-1940	1941-1950	1951-1960	1961-1970
1900	0	0	0	0	0	0	0
1905	0	0	0	0	0	0	0
1910	0.4	0	0	0	0	0	0
1915	0.1	0	0	0	0	0	0
1920	0.9	0	0	0	0	0	0
1925	5.7	0.2	0	0	0	0	0
1930	13.0	4.0	0.1	0	0	0	0
1935	18.0	15.8	0.4	0	0	0	0
1940	21.5	28.2	5.4	0	0	0	0
1945	23.9	33.5	23.1	0.8	0	0	0
1950	25.1	35.9	37.2	9.4	0	0	0
1955	25.4	36.8	41.8	28.9	0.6	0	0
1960	25.4	37.2	42.5	42.9	10.1	0.1	0
1965	24.3	36.0	41.6	43.9	30.5	1.1	0
1970	20.7	31.8	37.3	38.0	35.8	12.0	0.3
1975	15.4	28.5	35.5	40.0	39.3	32.7	3.2
1980	13.6	24.9	30.5	34.9	33.6	32.7	20.1
1985	7.6	17.6	27.5	30.7	32.0	33.6	29.2
1987	7.3	16.3	24.7	28.8	29.4	30.5	25.9

Figure 4. Changes in prevalence of cigarette smoking among successive birth cohorts of white U.S. males, 1900 to 1987

X Data	1901-1910	1911-1920	1921-1930	1931-1940	1941-1950	1951-1960	1961-1970
1900	0	0	0	0	0	0	0
1905	0	0	0	0	0	0	0
1910	0.4	0	0	0	0	0	0
1915	3.0	0	0	0	0	0	0
1920	16.5	0.2	0	0	0	0	0
1925	40.8	2.6	0	0	0	0	0
1930	58.0	17.5	0.5	0	0	0	0
1935	62.6	45.0	2.9	0	0	0	0
1940	62.9	62.9	18.1	0.3	0	0	0
1945	62.4	68.8	50.0	2.6	0	0	0
1950	59.9	66.0	66.8	19.0	0.2	0	0
1955	56.5	63.5	67.0	47.9	2.5	0	0
1960	52.4	60.2	64.0	62.4	19.7	0.2	0
1965	45.3	53.6	57.9	59.3	45.3	2.6	0
1970	31.8	41.9	45.5	47.1	48.0	18.3	0.4
1975	24.8	39.3	47.7	47.7	51.6	38.6	4.2
1980	18.0	29.7	39.5	42.0	42.9	39.0	20.2
1985	14.5	19.0	30.7	35.0	39.5	34.4	33.7
1987	13.5	16.4	27.6	31.4	35.6	30.8	31.0

Figure 5. Changes in prevalence of cigarette smoking among successive birth cohorts of black U.S. males, 1900 to 1987

X Data	1901-1910	1911-1920	1921-1930	1931-1940	1941-1950	1951-1960	1961-1970
1900	0	0	0	0	0	0	0
1905	0	0	0	0	0	0	0
1910	0.5	0	0	0	0	0	0
1915	1.7	0	0	0	0	0	0
1920	12.7	0.2	0	0	0	0	0
1925	30.9	2.7	0	0	0	0	0
1930	42.1	15.8	0.2	0	0	0	0
1935	46.6	38.7	2.2	0	0	0	0
1940	48.3	54.1	15.8	0.2	0	0	0
1945	48.6	57.6	44.3	2.5	0	0	0
1950	48.9	59.6	55.0	16.3	0	0	0
1955	47.8	55.8	57.2	39.4	1.0	0	0
1960	46.1	54.9	58.0	57.1	15.5	0.3	0
1965	43.6	54.0	55.7	56.5	41.3	2.2	0
1970	34.7	45.3	50.0	51.0	55.0	14.1	0
1975	33.9	47.8	51.1	55.3	57.9	39.2	1.5
1980	24.8	40.4	46.9	47.8	47.0	44.6	12.0
1985	25.3	29.4	42.3	47.8	45.5	46.1	28.5
1987	25.3	28.3	39.3	45.5	41.6	40.3	28.4

Figure 6. Changes in prevalence of cigarette smoking among successive birth cohorts of white U.S. females, 1900 to 1987

X Data	1901-1910	1911-1920	1921-1930	1931-1940	1941-1950	1951-1960	1961-1970
1900	0	0	0	0	0	0	0
1905	0	0	0	0	0	0	0
1910	0	0	0	0	0	0	0
1915	0.1	0	0	0	0	0	0
1920	0.8	0	0	0	0	0	0
1925	5.6	0.2	0	0	0	0	0
1930	13.2	4.2	0.1	0	0	0	0
1935	18.5	16.5	0.4	0	0	0	0
1940	22.2	29.5	5.4	0	0	0	0
1945	24.8	34.9	23.5	0.8	0	0	0
1950	25.9	37.4	38.0	9.6	0	0	0
1955	26.2	38.2	42.7	29.5	0.6	0	0
1960	26.2	38.8	43.3	43.7	10.3	0.1	0
1965	25.0	37.4	42.2	44.2	31.2	1.1	0
1970	21.2	33.0	37.7	37.9	35.9	12.4	0.4
1975	16.1	29.2	35.9	40.3	39.5	33.6	3.6
1980	14.5	25.3	30.5	35.0	33.7	33.0	22.0
1985	7.5	17.9	28.0	31.9	31.8	33.4	30.4
1987	7.5	16.6	25.3	30.0	29.1	30.1	28.9

Figure 7. Changes in prevalence of cigarette smoking among successive birth cohorts of black U.S. females, 1900 to 1987

X Data	1901-1910	1911-1920	1921-1930	1931-1940	1941-1950	1951-1960	1961-1970
1900	0	0	0	0	0	0	0
1905	0	0	0	0	0	0	0
1910	0	0	0	0	0	0	0
1915	0.6	0	0	0	0	0	0
1920	2.4	0	0	0	0	0	0
1925	6.6	0.6	0	0	0	0	0
1930	10.7	3.2	0.1	0	0	0	0
1935	13.2	9.4	0.4	0	0	0	0
1940	14.6	16.1	6.1	0	0	0	0
1945	17.0	20.4	20.3	1.0	0	0	0
1950	17.3	23.1	31.7	9.4	0.1	0	0
1955	17.0	24.6	35.0	25.9	0.5	0	0
1960	17.3	24.1	37.4	39.4	9.3	0.2	0
1965	16.7	23.3	37.4	44.3	26.6	0.9	0
1970	14.5	21.6	35.2	41.3	37.9	9.8	0.1
1975	8.1	23.8	33.6	41.0	41.3	28.5	1.7
1980	6.2	22.9	32.7	36.0	36.9	32.7	12.7
1985	9.7	12.7	28.3	25.7	37.8	37.4	23.5
1987	8.9	12.2	23.3	24.1	35.7	35.4	22.3

Figure 8. Age-adjusted cancer mortality rates, all males

X Data	All Sites Combined	Lung Cancer	All Other Cancers
1950	171.9	22.2	149.7
1955	182.9	34.6	148.3
1960	187.9	39.3	148.5
1965	197.8	48.7	149.1
1970	190.2	55.9	134.3
1975	212.2	68.7	145.5
1980	221.3	73.3	148.0
1985	218.8	73.9	144.9
1987	218.4	74.9	144.5

Figure 9. Age-adjusted cancer mortality rates, white males

X Data	All Sites Combined	Lung Cancer	All Other Cancers
1950	173.3	22.6	150.7
1955	183.1	35.2	147.9
1960	186.8	39.3	147.5
1965	196.2	48.8	147.4
1970	194.4	57.5	136.9
1975	207.7	65.7	142.0
1980	215.6	71.8	143.8
1985	212.5	72.2	140.3
1987	213.4	73.2	140.2

Figure 10. Age-adjusted cancer mortality rates, nonwhite males

X Data	All Sites Combined	Lung Cancer	All Other Cancers
1950	151.7	16.2	135.5
1955	176.9	27.3	149.6
1960	196.3	38.7	157.6
1965	211.9	47.0	164.9
1970	181.7	44.6	117.1
1975	252.0	74.9	177.2
1980	271.7	85.7	186.0
1985	271.3	87.3	184.0
1987	269.2	88.5	180.6

Figure 11. Age-adjusted cancer mortality rates, all females

X Data	All Sites Combined	Lung Cancer	All Other Cancers
1950	151.7	5.06	146.7
1955	145.6	5.92	139.7
1960	140.0	5.83	134.2
1965	136.4	7.78	128.7
1970	143.2	11.80	131.5
1975	134.2	15.60	118.6
1980	138.0	21.40	116.6
1985	139.3	26.40	112.9
1987	139.5	28.20	111.3

Figure 12. Age-adjusted cancer mortality rates, white females

X Data	All Sites Combined	Lung Cancer	All Other Cancers
1950	151.2	5.0	146.1
1955	145.1	5.8	139.2
1960	138.6	5.8	132.8
1965	135.1	7.6	127.5
1970	148.0	12.2	135.8
1975	132.3	15.6	116.6
1980	136.4	21.5	115.0
1985	138.2	26.8	111.4
1987	138.1	28.5	109.6

Figure 13. Age-adjusted cancer mortality rates, nonwhite females

X Data	All Sites Combined	Lung Cancer	All Other Cancers
1950	150.4	4.10	146.4
1955	144.1	6.10	137.9
1960	149.6	6.10	143.5
1965	145.2	7.50	137.7
1970	110.1	8.82	101.2
1975	156.5	16.00	140.5
1980	149.0	20.50	128.5
1985	146.9	23.20	123.7
1987	148.6	25.50	123.1

Figure 14. Changes in current smokers, ever-smokers, and lung cancer deaths, for white U.S. males born 1901 to 1910

X Data	Current	Ever	Lung Death
1900	0	0	0
1905	0	0	0
1910	0.4	0.4	0
1915	3.0	3.0	0
1920	16.5	16.7	0
1925	40.8	41.4	0
1930	58.0	59.2	0
1935	62.6	64.5	0
1940	62.9	66.1	0
1945	62.4	66.9	0
1950	59.9	67.1	1.7
1955	58.5	67.2	4.7
1960	52.4	67.4	9.0
1965	45.3	67.7	15.9
1970	31.8	67.8	26.0
1975	24.8	65.7	36.5
1980	18.0	64.3	47.4
1985	14.5	62.6	56.8
1987	13.4	62.6	

Figure 15. Changes in current smokers, ever-smokers, and lung cancer deaths, for black U.S. males born 1901 to 1910

X Data	Current	Ever	Lung Death
1900	0	0	0
1905	0	0	0
1910	0.5	0.5	0
1915	1.7	1.7	0
1920	12.7	12.7	0
1925	30.9	31.5	0
1930	42.1	43.3	0
1935	48.6	48.2	0
1940	48.3	50.3	0
1945	48.6	51.1	0
1950	48.9	52.1	1.6
1955	47.8	52.3	5.4
1960	46.1	52.7	10.0
1965	43.6	53.0	15.9
1970	34.7	53.0	25.8
1975	33.9	52.1	34.8
1980	24.8	48.4	44.5
1985	25.3	70.8	51.2
1987	25.3	70.8	

Figure 16. Changes in current smokers, ever-smokers, and lung cancer deaths, for white U.S. males born 1911 to 1920

X Data	Current	Ever	Lung Death
1900	0	0	0
1905	0	0	0
1910	0	0	0
1915	0	0	0
1920	0.2	0.2	0
1925	2.6	2.6	0
1930	17.5	17.7	0
1935	45.0	45.5	0
1940	62.9	64.0	0
1945	66.8	69.2	0
1950	66.0	70.7	0
1955	63.5	71.1	0
1960	60.2	71.3	2.3
1965	53.6	71.5	5.7
1970	41.9	71.6	11.5
1975	39.3	73.8	19.4
1980	29.7	72.2	30.1
1985	19.0	72.3	41.0
1987	16.4	72.3	

Figure 17. Changes in current smokers, ever-smokers, and lung cancer deaths, for black U.S. males born 1911 to 1920

X Data	Current	Ever	Lung Death
1900	0	0	0
1905	0	0	0
1910	0	0	0
1915	0	0	0
1920	0.2	0.2	0
1925	2.7	2.7	0
1930	15.8	15.8	0
1935	38.7	38.7	0
1940	54.1	54.7	0
1945	57.6	58.7	0
1950	56.8	59.6	0
1955	55.8	59.6	0
1960	54.9	60.0	3.7
1965	54.0	60.5	7.7
1970	45.3	62.7	18.6
1975	47.8	68.0	26.2
1980	40.4	65.7	37.5
1985	29.4	65.0	47.5
1987	28.3	65.0	

Figure 18. Changes in current smokers, ever-smokers, and lung cancer deaths, for white U.S. males born 1921 to 1930

X Data	Current	Ever	Lung Death
1900	0	0	0
1905	0	0	0
1910	0	0	0
1915	0	0	0
1920	0	0	0
1925	0	0	0
1930	0.5	0.5	0
1935	2.9	2.9	0
1940	18.1	18.2	0
1945	50.0	50.6	0
1950	66.8	69.0	0
1955	67.0	71.5	0
1960	64.0	72.0	0
1965	57.9	72.3	1.2
1970	45.5	72.5	3.3
1975	47.7	75.7	6.9
1980	39.5	75.8	12.8
1985	30.7	73.8	21.2
1987	27.6	73.9	

Figure 19. Changes in current smokers, ever-smokers, and lung cancer deaths, for black U.S. males born 1921 to 1930

X Data	Current	Ever	Lung Death
1900	0	0	0
1905	0	0	0
1910	0	0	0
1915	0	0	0
1920	0	0	0
1925	0	0	0
1930	0.2	0.2	0
1935	2.2	2.2	0
1940	15.8	15.7	0
1945	44.3	44.8	0
1950	55.0	56.4	0
1955	57.2	60.0	0
1960	58.0	61.6	0
1965	55.7	62.0	2.2
1970	50.0	62.5	5.9
1975	51.1	68.6	11.7
1980	46.9	68.1	19.5
1985	42.3	74.7	28.9
1987	39.3	74.7	

Figure 20. Changes in current smokers, ever-smokers, and lung cancer deaths, for white U.S. males born 1931 to 1940

X Data	Current	Ever	Lung Death
1900	0	0	0
1905	0	0	0
1910	0	0	0
1915	0	0	0
1920	0	0	0
1925	0	0	0
1930	0	0	0
1935	0	0	0
1940	0.3	0.3	0
1945	2.6	2.6	0
1950	19.0	19.2	0
1955	47.9	48.9	0
1960	62.4	65.4	0
1965	59.3	67.8	0
1970	47.1	68.5	0
1975	47.7	68.9	1.3
1980	42.0	70.9	3.1
1985	35.0	69.8	8.2
1987	31.4	69.8	

Figure 21. Changes in current smokers, ever-smokers, and lung cancer deaths, for black U.S. males born 1931 to 1940

X Data	Current	Ever	Lung Death
1900	0	0	0
1905	0	0	0
1910	0	0	0
1915	0	0	0
1920	0	0	0
1925	0	0	0
1930	0	0	0
1935	0	0	0
1940	0.2	0.2	0
1945	2.5	2.5	0
1950	16.3	16.3	0
1955	39.4	39.8	0
1960	57.1	57.6	0
1965	56.5	60.2	0
1970	51.0	62.1	0
1975	55.3	68.7	2.4
1980	47.8	67.4	5.5
1985	47.8	61.0	10.0
1987	45.5	61.0	

Figure 22. Changes in current smokers, ever-smokers, and lung cancer deaths, for white U.S. males born 1941 to 1950

X Data	Current	Ever	Lung Death
1900	0	0	0
1905	0	0	0
1910	0	0	0
1915	0	0	0
1920	0	0	0
1925	0	0	0
1930	0	0	0
1935	0	0	0
1940	0	0	0
1945	0	0	0
1950	0.2	0.2	0
1955	2.5	2.5	0
1960	19.7	19.9	0
1965	45.3	47.4	0
1970	48.0	61.4	0
1975	51.6	65.9	0
1980	42.9	68.2	0
1985	39.5	65.2	0.9
1987	35.6	65.3	

Figure 23. Changes in current smokers, ever-smokers, and lung cancer deaths, for black U.S. males born 1941 to 1950

X Data	Current	Ever	Lung Death
1900	0	0	0
1905	0	0	0
1910	0	0	0
1915	0	0	0
1920	0	0	0
1925	0	0	0
1930	0	0	0
1935	0	0	0
1940	0	0	0
1945	0	0	0
1950	0	0	0
1955	1	1	0
1960	15.5	15.6	0
1965	41.3	42.4	0
1970	55.0	60.3	0
1975	57.9	64.7	0
1980	47.0	63.1	0
1985	45.5	64.1	1.7
1987	41.6	64.1	

Figure 24. Changes in current smokers, ever-smokers, and lung cancer deaths, for white U.S. females born 1901 to 1910

X Data	Current	Ever	Lung Death
1900	0	0	0
1905	0	0	0
1910	0	0	0
1915	0.1	0.1	0
1920	0.8	0.9	0
1925	5.6	5.7	0
1930	13.2	13.4	0
1935	18.5	18.8	0
1940	22.2	22.8	0
1945	24.6	25.6	0
1950	25.9	27.5	0.35
1955	26.2	28.4	0.68
1960	26.2	29.4	1.2
1965	25.0	29.8	2.2
1970	21.2	30.2	4.1
1975	16.1	27.9	6.5
1980	14.5	27.5	10.3
1985	7.5	20.1	13.6
1987	7.2	20.1	

Figure 25. Changes in current smokers, ever-smokers, and lung cancer deaths, for black U.S. females born 1901 to 1910

X Data	Current	Ever	Lung Death
1900	0	0	0
1905	0	0	0
1910	0	0	0
1915	0.6	0.6	0
1920	2.4	2.4	0
1925	6.6	6.6	0
1930	10.7	10.7	0
1935	13.2	13.2	0
1940	14.6	14.6	0
1945	17.0	17.2	0
1950	17.3	18.9	0.4
1955	17.0	19.7	1.1
1960	17.3	20.5	1.3
1965	16.7	20.6	2.4
1970	14.5	21.3	3.5
1975	8.1	17.0	7.9
1980	6.2	16.1	8.4
1985	9.7	17.2	10.1
1987	8.9	17.2	

Figure 26. Changes in current smokers, ever-smokers, and lung cancer deaths, for white U.S. females born 1911 to 1920

X Data	Current	Ever	Lung Death
1900	0	0	0
1905	0	0	0
1910	0	0	0
1915	0	0	0
1920	0	0	0
1925	0.2	0.2	0
1930	4.2	4.2	0
1935	16.5	16.8	0
1940	29.5	30.0	0
1945	34.9	35.9	0
1950	37.4	39.3	0
1955	38.2	41.0	0
1960	38.8	42.6	0.6
1965	37.4	43.4	1.4
1970	33.0	44.0	3.0
1975	29.2	42.9	5.5
1980	25.3	42.8	9.3
1985	17.9	37.4	14.6
1987	16.6	37.4	

Figure 27. Changes in current smokers, ever-smokers, and lung cancer deaths, for black U.S. females born 1911 to 1920

X Data	Current	Ever	Lung Death
1900	0	0	0
1905	0	0	0
1910	0	0	0
1915	0	0	0
1920	0	0	0
1925	0.6	0.6	0
1930	3.2	3.2	0
1935	9.4	9.6	0
1940	16.1	16.5	0
1945	20.4	20.9	0
1950	23.1	24.0	0
1955	24.6	25.9	0
1960	24.1	26.7	0.7
1965	23.3	26.8	1.5
1970	21.6	27.7	3.0
1975	23.8	33.7	4.6
1980	22.9	36.1	8.0
1985	12.7	26.0	10.9
1987	12.2	26.0	



Figure 28. Changes in current smokers, ever-smokers, and lung cancer deaths, for white U.S. females born 1921 to 1930

X Data	Current	Ever	Lung Death
1900	0	0	0
1905	0	0	0
1910	0	0	0
1915	0	0	0
1920	0	0	0
1925	0	0	0
1930	0.1	0.1	0
1935	0.4	0.4	0
1940	5.4	5.4	0
1945	23.5	24.1	0
1950	38.0	39.4	0
1955	42.7	44.8	0
1960	43.3	46.8	0
1965	42.2	48.2	0.4
1970	37.7	48.8	1.2
1975	35.9	47.3	2.7
1980	30.5	46.3	5.2
1985	28.0	47.5	9.2
1987	25.3	47.5	

Figure 29. Changes in current smokers, ever-smokers, and lung cancer deaths, for black U.S. females born 1921 to 1930

X Data	Current	Ever	Lung Death
1900	0	0	0
1905	0	0	0
1910	0	0	0
1915	0	0	0
1920	0	0	0
1925	0	0	0
1930	0.1	0.1	0
1935	0.4	0.4	0
1940	6.1	6.1	0
1945	20.3	20.3	0
1950	31.7	32.0	0
1955	35.0	36.3	0
1960	37.3	39.1	0
1965	37.4	40.5	0.6
1970	35.2	42.2	1.5
1975	33.6	43.7	2.8
1980	32.7	47.8	5.6
1985	28.3	43.9	8.8
1987	23.3	43.9	

Figure 30. Changes in current smokers, ever-smokers, and lung cancer deaths, for white U.S. females born 1931 to 1940

X Data	Current	Ever	Lung Death
1900	0	0	0
1905	0	0	0
1910	0	0	0
1915	0	0	0
1920	0	0	0
1925	0	0	0
1930	0	0	0
1935	0	0	0
1940	0	0	0
1945	0.8	0.8	0
1950	9.6	9.7	0
1955	29.5	30.2	0
1960	43.7	46.3	0
1965	44.2	50.0	0
1970	37.9	51.5	0
1975	40.3	51.1	0.7
1980	35.0	51.2	1.7
1985	31.9	50.1	3.5
1987	30.0	50.1	

Figure 31. Changes in current smokers, ever-smokers, and lung cancer deaths, for black U.S. females born 1931 to 1940

X Data	Current	Ever	Lung Death
1900	0	0	0
1905	0	0	0
1910	0	0	0
1915	0	0	0
1920	0	0	0
1925	0	0	0
1930	0	0	0
1935	0	0	0
1940	0	0	0
1945	1.0	1.0	0
1950	8.4	8.5	0
1955	25.9	26.0	0
1960	39.4	39.9	0
1965	44.3	48.4	0
1970	41.3	49.1	0
1975	41.0	47.8	0.8
1980	36.0	45.7	2.0
1985	26.7	39.5	3.3
1987	24.1	39.5	

Figure 32. Changes in current smokers, ever-smokers, and lung cancer deaths, for white U.S. females born 1941 to 1950

X Data	Current	Ever	Lung Death
1900	0	0	0
1905	0	0	0
1910	0	0	0
1915	0	0	0
1920	0	0	0
1925	0	0	0
1930	0	0	0
1935	0	0	0
1940	0	0	0
1945	0	0	0
1950	0	0	0
1955	0.6	0.6	0
1960	10.3	10.5	0
1965	31.2	33.3	0
1970	35.9	46.9	0
1975	39.5	49.0	0
1980	33.7	49.7	0
1985	31.8	49.4	0.6
1987	29.1	49.5	

Figure 33. Changes in current smokers, ever-smokers, and lung cancer deaths, for black U.S. females born 1941 to 1950

X Data	Current	Ever	Lung Death
1900	0	0	0
1905	0	0	0
1910	0	0	0
1915	0	0	0
1920	0	0	0
1925	0	0	0
1930	0	0	0
1935	0	0	0
1940	0	0	0
1945	0	0	0
1950	0.1	0.1	0
1955	0.5	0.5	0
1960	9.3	9.3	0
1965	26.6	26.9	0
1970	37.9	41.8	0
1975	41.3	44.4	0
1980	36.9	46.0	0
1985	37.8	49.1	0.6
1987	35.7	49.4	

## Chapter 4

# Approaches Directed to the Individual

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## Chapter 4

# Approaches Directed to the Individual

### INTRODUCTION

The goal of any smoking control strategy is to influence individuals to choose nonsmoking status. Early efforts attempted to promote changes within the individual that would allow people to alter their behavior regardless of the social and environmental influences promoting smoking. More recently, public health professionals have recognized the need to change the smoking environment to provide persistent messages to quit and to encourage those who have quit not to relapse. Regardless of the smoking control strategy adopted, however, change must begin with the individual's choices. As a result, a major effort of any comprehensive smoking control strategy should be focused directly on the individual.

Three major approaches to the individual can be identified: (1) The first consists of public information campaigns that inform the smoker of the disease risks associated with smoking and continually present this information as a motivation for smoking cessation. (2) The second is the delivery of school-based health education curricula designed to prevent initiation of tobacco use by adolescents. (3) The third is the development of programs and clinics that smokers can use individually or in groups to improve the likelihood of long-term success with cessation attempts. Each of these approaches has important effects on the social environment and contributes synergistically to other components of a comprehensive smoking control effort; however, their major focus is on the individual.

### PUBLIC INFORMATION CAMPAIGNS

The changing role of the media in portraying cigarettes reflects the evolution of mass communication. The severe deleterious impact of smoking on health makes cigarette advertising a special concern. The past and present influence of tobacco companies, expressed through billions of advertising dollars, has both promoted tobacco use and effectively censored information on the adverse health consequences of tobacco use in most print media (Wallack, 1989; Warner, 1981 and 1985). This section reviews the historical role of the mass media and describes how cigarettes have been portrayed to the public by both protobacco and antitobacco groups. Modern antismoking media campaigns also are analyzed and discussed.

Hand-rolled, paper-wrapped cigarettes were first heavily marketed at the beginning of the 20th century, partly in response to public health campaigns against chewing tobacco. Such campaigns alleged that the practice of spitting tobacco

juice and wads onto streets and into cuspidors was a major contributor to the spread of tuberculosis and other communicable diseases. During this time, a new strain of tobacco that was much milder than cigar tobacco appeared on the market. For economic reasons and to expand their markets, the tobacco companies promoted a new milder cigarette as an alternative to chewing tobacco and as a product that offered a lower dose of nicotine. The development of cigarette rolling machines made the mass production of cigarettes more efficient and the products more available (Consumers Union, 1972).

Anticigarette campaigns were sponsored by educators, reformers, business leaders, and respected public figures in reaction to the marketing of the new milder, paper-wrapped cigarettes. In particular, the campaigns were designed to prevent smoking by women and children (Diehl, 1969; Troyer and Markle, 1983).

Although some groups opposed smoking for health reasons, others attacked smoking as a moral issue. They claimed that cigarette smoking affected the brain and therefore contributed to degeneracy. Ultimately, the campaigns resulted in legislation that prohibited or limited cigarette smoking in most states by the early 1920's. The impact of the laws on behavior was negligible, however. By 1927, the few states that still had smoking prohibition laws simply restricted sales to minors.

Medical evidence that linked the increasing number of lung cancer deaths to smoking began to emerge in the United States in the late 1930's. Several researchers investigated the relationship between the tobacco industry's expenditures on mass media and the media's coverage of the risks of smoking. Even though the evidence linking smoking to lung cancer was newsworthy and was presented at press conferences, most newspapers and magazines censored the information, possibly because they feared the loss of advertising revenue (Bagdikian, 1983; Cirino, 1972; Consumers Union, 1972). Two major New York daily newspapers that carried limited information about the evidence restricted their stories to a few paragraphs placed inconspicuously in the middle or back of the paper (Bagdikian, 1983).

The revenue provided by tobacco advertisers has continued to suppress the presentation of the strong empirical relationship between smoking and health problems (Warner, 1985). Cirino (1972) reported that, from 1938 to 1955, only limited coverage was given to scientific evidence of the suspected link between smoking and lung cancer. At that time, the tobacco industry was a leading advertiser in newspapers and magazines in the United States. The tobacco companies

routinely screened magazines and newspapers prior to publication to find articles dealing with the relationship between smoking and health, and they withheld advertising from issues that contained information on the negative health effects of smoking (Warner, 1985).

#### Counter-advertising in the 1960's

The publication of the Surgeon General's Report in 1964 was accompanied by substantial media exposure. The impact of the mass media coverage was a 15 to 20 percent fall in cigarette sales across the United States within a few weeks of the report's release (Consumers Union, 1972); however, that impact was short-lived.

Cigarette consumption returned almost to pre-1964 levels within 1 year after the release of the Surgeon General's Report. Public health agencies launched several television-based anti-smoking campaigns between 1964 and 1970. The Consumers Union (1972) reported that mass media campaigns launched subsequent to the 1964 Surgeon General's Report had the following objectives: (1) to increase awareness of the negative health effects of smoking, (2) to promote abstinence among teenagers, and (3) to motivate current smokers to quit.

Several conclusions have been drawn from reviews of the early mass media campaigns against cigarettes and the influence of cigarette advertising (Consumers Union, 1972; Flay, 1987; Warner, 1981). The consensus was that mass media campaigns enhanced awareness of the detrimental effects of smoking on health. Such campaigns were found to motivate nonsmokers to abstain from smoking, at least temporarily. However, the antismoking educational campaigns seemed to have little sustained effect on changing the behavior of habitual smokers. Cigarette advertising was suggested to have a substantial influence on a young person's decision to start smoking.

#### Persuasion Approaches of The 1970's and 1980's

Cigarette advertising associates smoking with enjoyment of life. Specifically, the advertising connects smoking with popular music, enhanced sexuality, popularity, and general happiness—overall, a very appealing message to adolescents. Furthermore, low-tar, low-nicotine cigarettes have been promoted by tobacco companies as less harmful alternatives to brands that have higher tar and nicotine concentrations. These advertising campaigns were found to be effective in motivating individuals who are concerned about their health to switch brands rather than to quit smoking. Almost 15 to 20 years later, the earlier conclusions presented by the Consumers Union have been replicated by additional research on the mass media, the tobacco industry, and advertising (Flay, 1987; Wallace, 1989; Warner, 1985; Warner et al., 1986).

#### Early Presentation Of Smoking's Hazards

To counter the financially and politically powerful tobacco industry, professionals in public health, communications, and education and political lobbying groups have conducted numerous mass media campaigns and interventions during the past 30 years. More sophisticated appeals, designed to promote abstinence or facilitate cessation, evolved from initial educational campaigns of the late 1960's and early 1970's. However, cigarette advertising and promotion expenditures also increased, from approximately \$491 million in 1975 to more than \$3 billion in 1988 in the United States (Centers for Disease Control, 1990).

The results of the U.S. public health campaigns conducted from 1967 to 1970 suggested sustained counteradvertising did affect the smoking-related beliefs and behaviors of many cigarette smokers (Warner, 1981). The results also suggested a dose-response relationship: As counteradvertising was increased and maintained, smoking prevalence decreased (Flay, 1987).

Flay (1987) reviewed 40 mass media programs and campaigns conducted in the past 30 years, evaluating their relative effectiveness in changing smoking prevalence rates and in sustaining quit rates. Comparing the programs and campaigns, however, was problematic. Most evaluations utilized posttest-only or single-group designs without randomization, and quasi-experimental designs made it difficult to attribute changes in smoking status to the program or campaign. However, several criteria were noted to maximize the effects of media campaigns against cigarettes (Flay, 1987), including the presentation of several different messages over a short time, widespread dissemination of information among the target audience, frequent airing of the messages, and long-term implementation of the advertising campaign.

Flay concluded that viewing a cessation program message on television was as effective for viewers as the American Lung Association self-help manuals were for requestors. The television programs, in combination with the manuals, were found to be more effective than the American Lung Association manuals alone. Moreover, the media viewing plus social support condition was found to be the most effective mass media condition in that study.

Using their integration of prevailing theory, Flay and Burton (1988) proposed the following six necessary and interrelated conditions for an effective campaign: (1) The campaign should include high-quality messages, information sources, and media channels. (2) The message must be disseminated to the target audience and presented frequently, with some variety, over a long duration and at optimal viewing times.

(3) The campaign must retain the audience's attention by ensuring the quality of the message, providing appropriate and supportive media channels, and ensuring that the message corresponds to audience characteristics. (4) Interpersonal communication among members of the target audience should be encouraged. Groups with opposing viewpoints should be encouraged to exchange dialogue that might influence social norms. (5) The campaign should facilitate changes in individuals in the target audience. For example, dialogue between smokers and nonsmokers could enhance smokers' awareness of their behavior's undesirable effects on others. (6) The campaign should influence social norms against smoking. Social norms might also be influenced by dialogue between legislators and their constituents; voter support of an increase in the excise tax on cigarettes might be one example.

A strategy often neglected in mass media campaigns has been to provide smokers with the requisite skills to quit smoking and to provide nonsmokers with the skills needed to remain abstinent (McAlister et al., 1989). Campaigns that have attempted to address these issues have done so primarily through applications of Bandura's social learning theory (i.e., the concepts of modeling, self-efficacy, and social support; Bandura, 1977). Television has been a popular medium for demonstration programs in which celebrities or trained individuals serving as role models provide specific instructions and demonstrate skills that the audience is encouraged to emulate (Flay, 1987; McAlister et al., 1989).

Three examples of such demonstration programs were discussed by McAlister and associates (1989). Each demonstration was a large-scale project, one of which was implemented on a national level throughout Finland. The remaining programs were community programs—one in the county of North Karelia, Finland, and the other in Houston, Texas. The results of the Finnish national program were reported in detail by Puska and colleagues (1979). In brief, the national project was a television-based program that featured a role model who was trained to facilitate successful coping strategies and who then guided a group of smokers through the stages of smoking cessation. The authors reported that, of the 30,000 to 40,000 smokers who participated in the televised series, approximately 10,000 former smokers credited the first year of their nonsmoking status to the program.

The community projects carried the mass media approach to smoking cessation a step further. In North Karelia, a comprehensive program for cardiovascular risk reduction included a smoking cessation component. In addition to a televised cessation series, the program included recruitment and training of 805 volunteers to provide social reinforcement to individuals

trying to quit smoking. The volunteers were also given self-help manuals to distribute to those individuals, and they reported success in helping approximately 500 smokers to quit (McAlister et al., 1989).

The Houston project ran concurrently with the American Cancer Society's Great American Smokeout. The media outlets used included the most widely viewed television station in Houston and one of the two city newspapers. Trained role models, who volunteered to attempt to quit smoking, were presented in specific programs, news announcements, and public service announcements. The role models were videotaped not only during group counseling sessions but also as they went about their daily activities. As part of the project's comprehensive approach, newspaper announcements featured motivational statements and specific instructions for cessation, and printed materials were distributed by local pharmacies and grocery stores (McAlister et al., 1989). Brief training and printed materials were also provided to community public schools and large businesses. The results indicated that 20,000 to 40,000 individuals quit smoking as a result of this campaign.

There have been a number of excellent reviews of school-based programs to prevent smoking published in the last dozen years (Bell and Battjes, 1985; Best et al., 1988; Borvin, 1986; Cleary et al., 1988; Flay, 1985; Flay et al., 1983; Glynn and Haenlein, 1988; Glynn et al., 1983; Goodstadt, 1978; Leventhal and Cleary, 1980; Schaps et al., 1981; Snow et al., 1985; Sussman, 1989; Thompson, 1978; Tobler, 1986; US DHEW, 1979; US DHHS, 1989). These reviews provide careful methodological critiques of published studies that must precede any attempt to draw general conclusions from such varied and extensive literature. Although they differ in their enthusiasm for the interventions tested to date, the reviewers agree that the so-called traditional approaches to smoking prevention are largely ineffective and that approaches based on the social-psychological models are at least modestly effective across a variety of settings, times, and populations.

The interventions reviewed here are presented in historical sequence and grouped by common concepts, and their similarities and differences are noted. Several of the intervention methods discussed here are now under study in projects too recent to have been included in previous reviews or to have published results.

The information model presumes that teaching adolescents that smoking is harmful will modify their attitudes and beliefs, which in turn will alter their smoking behavior. Information programs use various methods, including films, lectures, discussions, posters, pamphlets, newspaper articles, and

guest speakers, to provide factual information on what tobacco products consist of, how they are used, and what effect they have on health, especially long-term health outcomes (Goodstadt, 1978; Schaps et al., 1981; Thompson, 1978; US DHEW, 1979).

Although there is substantial evidence linking beliefs and attitudes with behavior (Fishbein, 1967; Fishbein and Ajzen, 1975; Hovland et al., 1953; McGuire, 1964 and 1969), the information model presumes that knowledge is the major determinant of behavior and thereby ignores the many complex social and personal factors that play an important role in the development of smoking among adolescents. The two major reviews of the smoking prevention literature based on the information model concluded that it was largely ineffective (Goodstadt, 1978; Thompson, 1978). In spite of these findings, the information model continues to predominate in school-based programs for smoking prevention outside the research milieu (Murray et al., 1988).

#### Affective Model

The affective model assumes that tobacco use is influenced largely by attitudes. Programs based on the affective model attempt to enhance self-esteem and self-image, to teach stress management and stress reduction, to clarify the student's values and show that tobacco use is inconsistent with those values, to improve decisionmaking, and to encourage greater achievement through goal-setting. Such programs often do not include specific information about tobacco or drug use (Durell and Bukoski, 1984; Goodstadt, 1978). The affective model evolved as educators and researchers recognized that the information model was inadequate and that youth who became involved with smoking or drugs often had a negative self-image, were poor achievers, had trouble making healthy decisions, and were under multiple stressors from their social environments.

Although attitude change can be an important component of behavior change, there is substantial evidence that the individual must also possess the skills to carry out the desired behaviors and believe that he or she can successfully execute those behaviors and that the behaviors will have the desired effect (Bandura, 1977; Maiman and Becker, 1974). There is little evidence that programs based only on the affective model have any beneficial effect on behavior with respect to tobacco or drug use (Hansen et al., 1988; Schaps et al., 1981; Tobler, 1986).

Three major social-psychological approaches have evolved as alternatives to the traditional approaches described above. These psychosocial models are the social influences model, the cognitive behavioral model, and the life skills model.

#### Development and Application of Psychosocial Approaches

#### EVOLUTION OF SCHOOL-BASED INTERVENTIONS

#### Traditional Approaches Information Model

The *social influences model* recognizes smoking in adolescence as primarily a social behavior. This model includes the following four components: (1) information on the negative social effects and short-term physiological consequences of tobacco use; (2) information on the social influences that encourage smoking among adolescents, particularly peer, parent, and mass media influences; (3) correction of inflated normative expectations of the prevalence of adolescent smoking; and (4) training, modeling, rehearsing, and reinforcing of methods to resist those influences and to communicate that resistance to others, particularly peers (Evans, 1976, 1983, and 1984; Evans et al., 1978, 1981, and 1984; Evans and Raines, 1982).

The initial effort also employed older peer leaders as facilitators and included a public commitment by the adolescent to not become a regular smoker (McAlister et al., 1979 and 1980; Perry et al., 1980a; Telch et al., 1982) or employed same-age peer leaders to increase the utility and visibility of leaders outside the formal classroom sessions (Hurd et al., 1980; Luepker et al., 1983). Jason (1979) experimented with modeling and rehearsing of pressure resistance skills but did not include the other elements of the social influences model and involved a single focus group of ninth graders. Evans (1976, 1982, 1984, and 1990) describes the social influences model as *social inoculation*. This model involves increasing children and adolescents' resistance to social influences that promote smoking by "inoculating" youth with knowledge and social skills for resisting such pressures. Furthermore, social inoculation includes training to understand and cope with not only overt social influences to smoke but also more subtle influences, such as smoking models in cigarette advertisements or individual perceptions of peer group smoking norms.

The *cognitive behavioral model* assumes that smoking is the result of both social and psychological factors, and therefore tobacco use is learned as an approach to meeting social needs (e.g., stress reduction, conversation supplement, transition marking). The cognitive behavioral model differs from the social influences model by including several intervention components that address belief-attitude-behavior structures that may increase adolescents' risk for tobacco use, and by using other than tobacco-related examples and settings as part of its generic social skills training. The earliest examples drew heavily on problem behavior theory (Jessor and Jessor, 1977) and cognitive behavior therapy (Kendall and Hollon, 1979).

The cognitive behavioral approach adopts the basic social influences model and adds role-playing, rehearsal, and reinforcement of pressure resistance skills. It includes problem-solving, decision-making, and self-control methods (Kendall

and Hollon, 1979) to teach adolescents how to recognize risks and manage initial impulses until they are able to evaluate options and select appropriate responses. It also includes self-reward methods (Bandura, 1977) to improve self-efficacy and to teach students to reward themselves for correct decisions. Early studies, like those based on the social influences model, showed positive results (Gilchrist et al., 1979; Schinke and Blythe, 1981; Schinke and Gilchrist, 1983) but were subject to a number of methodological limitations (for a discussion, see Flay, 1985).

The *life skills model* incorporates the four elements of the social influences model; the decision-making, problem-solving, self-control, and self-reward strategies from the cognitive behavioral model; and methods to develop greater autonomy, self-esteem, and self-confidence from the affective model. Even more than the cognitive behavioral model, the life skills model provides training to help adolescents cope with social challenges, including those that involve tobacco.

The life skills training program used a social-psychological approach and had promising results. A 10-session life skills training program reduced the incidence of new smoking by 75 percent in one study involving 8th, 9th, and 10th graders (Botvin et al., 1980). Botvin and Eng (1982), in a 12-session life skills training program involving only seventh graders, showed students smoking less at 1-year followup, reducing new smoking by a significant 58 percent. The 12-session life skills training program is described in Table 1.

Table 2 presents a comparison of some psychosocial school-based interventions. Included are the intervention grades, frequency and number of sessions, the intervention administrator, and size of the study population.

The following sections summarize subsequent work on the three psychosocial models, especially refinements and applications along the following four dimensions: (1) program variations, involving the type of instructor, the timing and spacing of the sessions, the targeted age group, and use of media supplements; (2) the addition of complementary delivery channels such as mass media, community organizations, and parent involvement; (3) the addition of complementary target outcomes such as substance use, nutrition, physical activity, and other health behaviors; and (4) long-term followup studies. For each model, the concluding paragraphs describe current and planned activities. It is notable that, in the course of continued development, there has been a gradual merging of the components of three psychosocial models.

Table 1  
A 12-session life skills training program

Session	Topics
Orientation	General introduction, saliva collection, pretest questionnaires
Smoking: myths and realities	Common attitudes and beliefs about smoking, prevalence of smoking, reasons for and against smoking, process of becoming addicted, decreasing social acceptance of smoking
Smoking and biofeedback	Effects of smoking on carbon monoxide levels and heart rate
Self-image and self-improvement	Self-image and how it is formed, self-image and behavior, importance of positive self-image, improving self-image
Decision-making and independent thinking	General decision-making strategies, sources of influence affecting decisions, resisting persuasive tactics, importance of independent thinking
Advertising techniques	Use and function of advertising, ad techniques, identifying ad techniques in cigarette ads and how they affect consumers' behavior, alternate ways to respond to these ads
Coping with anxiety	Situations causing anxiety, demonstration and practice of techniques for coping with anxiety
Communications skills	Verbal and nonverbal communication, learning to communicate effectively, techniques for avoiding misunderstanding
Social skills A	Overcoming shyness, initiating social contacts, giving and receiving compliments, basic conversational skills
Social skills B	Boy-girl relationships, nature of attraction, conversing with the opposite sex, asking someone for a date
Assertiveness	Situations calling for assertiveness, reasons for not being assertive, verbal and nonverbal assertive skills, resisting peer pressure to smoke
Conclusion	Review, conclusions, saliva collection, posttest questionnaires

Adapted from Botvin and Eng (1982). Sessions were 1 hour in length, and there was one session per week for 12 weeks.

**Social Influences Model** *Program variations.* Variations in the programs consist of changes in delivery of the instructional material, age of the students, use of media supplements, involvement of parents, and rewards for low smoking rates. Positive effects have been reported when the social influences model was delivered by project staff (rather than classroom teachers) (Coe et al., 1982; Dielman et al., 1985; Jason et al., 1982; Shaffer et al., 1983; Spitzzeri and Jason, 1979). Coe and colleagues (1982) used freshman medical students, who learned the intervention

Table 2  
A comparison of some psychosocial school-based interventions

	Intervention Grades	Number of Sessions	Frequency of Sessions	Intervention Administrator	Booster Sessions	Study Population
<b>Investigators</b>						
<i>Social Influences Model</i>						
Coe et al., 1982	7 or 8	8	Weekly or twice weekly	Program staff	No	30-40
Jason et al., 1982	9	7	Weekly	Program staff	No	149
Spitzzeri and Jason, 1979	9	10	Weekly	Program staff	No	61
Evans, 1976	7	4	Consecutive days	Peers	No	750
Pentz et al., 1989b	6-7	10		Peers, parents, and teachers	Yes	1,122
Ellickson and Bell, 1990	7-8	8	Weekly	Health educators, peers, and teachers	Yes	3,852
Best et al., 1984	6	6	Weekly	Program staff	Yes	654
Flay et al., 1983	6	6	Weekly	Program staff	Yes	653
Flay et al., 1987	7	5	Consecutive days	Teacher	No	4,891
<i>Cognitive Behavioral Model</i>						
Gilchrist et al., 1986	5-6	8		Peers and program staff	No	741
Schinke et al., 1985a	6	10	Weekly	Program staff	No	689
Schinke and Gilchrist, 1984	6	8	Semiweekly	Program staff	No	234
Gilchrist et al., 1989	6	10		Health educators	No	882
<i>Life Skills Model</i>						
Tell et al., 1984	5-7	10	Over 2 years	Peers and program staff	No	298
Botvin et al., 1983	7	15	Weekly or daily	Teachers	Yes	902
Bush et al., 1989	4-6	4	Over school year	Teachers	No	1,234
Botvin et al., 1990	8-10	10	Weekly	Program staff	No	281
Walter et al., 1989	4-9	Throughout school year	Weekly	Teachers	Yes	1,105
Botvin et al., 1984	7	20	Weekly	Older peers and teachers	No	1,311
Botvin and Eng, 1982	7	12	Weekly	Older peers	No	426



techniques in eight 1-hour sessions during regular school hours with the teacher present. The intervention strategies of Jason et al. (1982) were delivered by graduate psychology students in six weekly sessions lasting about 30 minutes each. Spitzzeri and Jason (1979) used clinical psychology graduate students, divided treatment classes into groups of 10, and engaged in role-playing scenes that lasted 5 to 10 minutes and were followed by 15 to 20 minutes of discussion.

A number of studies have used teachers to deliver the intervention program. Biglan et al. (1987a and 1987b) had science or health teachers present instruction sessions that ran for 3 or 4 consecutive days and were followed by a booster session, 2 weeks later, which emphasized refusal skills. Colquhoun and Cullen (1981) used a program of six 75-minute sessions conducted by teachers, with participation from local general practitioners. Colquhoun and Cullen reported smoking declines for 12-year-old boys from 11 percent to 4 percent 1 year later and, in 13- to 14-year-olds, declines from 20 percent to 14 percent in boys and 31 percent to 26 percent in girls.

Flay and coworkers (1987) delivered a 5-day classroom curriculum that was taught the same week that a local television station aired five 5-minute smoking prevention segments. There were an additional five 5-minute television segments on smoking cessation the following week. Pentz and colleagues (1989a and 1989b) had teachers deliver the intervention program in health, science, or social studies classes and reinforced classroom instruction with 10 homework sessions involving interviews and role-playing with parents and families.

A number of studies have combined staff or teacher delivery of program material with the assistance of a student peer. Arkin and colleagues (1981) involved all seventh grade classes of eight junior high schools (3,206 students at the program's start). Each seventh grade class nominated classmates who they believed would be effective leaders. The peer leaders directed discussions, provided feedback, and helped students to develop counterarguments. Ellickson and Bell (1990) used health educators to deliver the program to seventh graders in 10 schools, and teen leaders assisted adult teachers in 10 other schools. Perry and coworkers (1989), in a study of strategies to promote cardiovascular health, used same-age peer leaders in a smoking cessation program aimed at seventh graders. Murray and colleagues (1984, 1987, 1988, and 1989) employed a combination of teacher-led and peer-led intervention sessions and then tracked the participants for 6 years. They reported a significant reduction of smoking onset at 1 year, but the effect diminished with the passage of time.

Positive effects were reported also when the prevention program was delivered to elementary school students (Best et al., 1984; Dielman et al., 1985; Flay et al., 1983 and 1985). Best and colleagues (1984) included sixth graders from 22 schools in a social influences smoking prevention program. At the end of the eighth grade, 47 percent of never-smokers in the control group still had not tried smoking, and 60 percent of the treatment group never-smokers still had not smoked.

Johnson et al. (1986) delivered a social approach curriculum and a health approach curriculum aimed at Los Angeles area high school students. They concluded that social influence resistance training helps to reduce transitions to higher use by smoking experimenters. Health education was most valuable in preventing initial experimentation among those who were nonsmokers prior to the study.

Perry and coworkers (1980b), in the area of Stanford, California, examined a smoking prevention and cessation program delivered in regular 10th grade health education classes. On consecutive days during the fall semester, students received four 45-minute classes that covered handling social pressures to smoke, identifying and discussing the targets of cigarette advertisements, and brainstorming about how to help others remain nonsmokers or quit smoking. The students also measured their blood pressure, pulse rate, lung capacity, skin temperature, and carbon monoxide levels in breath. At the end of the semester, students in the program were more knowledgeable about the immediate physiological effects of smoking and about the best methods to quit and prevent others from smoking.

In a similar study, Perry and colleagues (1983) had 20 classes of 10th graders participate in a comparison of three treatment programs: the first was the social consequences of smoking; the second was the immediate and long-term physiological effects of smoking; and the third was the long-term health effects of smoking. The investigators cautioned that no single program appeared to be more effective than the other two, although the combined effect of all three programs was a 23 percent reduction of regular weekly smoking at 2-month followup.

Not all researchers have been able to replicate earlier reports (Best et al., 1988). Clarke and associates (1986) concluded that interventions led by program staff, which were "relatively light, short-term interventions," had little effect in an environment filled with powerful prosmoking messages by media, older peers, and adult role models.

Failure to achieve significant results in programs led by teachers have been reported by Lloyd et al. (1983), Clarke et al. (1986), and Burke et al. (1987). Lloyd and coworkers (1983)

surveyed teachers about their own smoking habits, attitudes toward smoking, and prior use of smoking prevention material. Teachers who rated lowest on this implementation scale had students whose test results for knowledge and behavior changes were similar to those for control students. Fisher et al. (1985), Clarke et al. (1986), and Burke et al. (1987) reported inconclusive results with programs that used a combination of teachers or program staff and peer leaders.

Several investigators have used mass media to supplement the more typical delivery approaches. Arkin et al. (1981) followed students who had received a social pressures curriculum and were nonsmokers at baseline. At followup, the percentages of students who were still nonsmokers for the adult-led sessions with media, peer-led with media, and peer-led without media were 82.1 percent, 81.0 percent, and 88.6 percent, respectively (students who received a standard curriculum were 69 percent nonsmokers). The addition of mass media did not provide a significant benefit in this study.

Murray et al. (1984, 1987, and 1988) reported similar results, in that adding videotape supplements to the social influences curriculum provided no additional benefits. Johnson et al. (1986) used a social influences curriculum to test the effect of recognizable compared with unfamiliar media models and reported no effects of the media models for any onset category or for quitting.

*Complementary delivery channels.* Biglan and associates (1987a) included a set of four messages mailed to the parents of seventh grade students. The object of the messages was to help reinforce refusal skills, health effects, and commitment to nonsmoking. The messages also tried to encourage parents to discuss their views of smoking with their children and to set family rules about smoking. The first message was mailed at the end of the school intervention, and subsequent messages at 2, 4, and 6 weeks thereafter. The investigators concluded that messages to and through parents did not affect the outcome.

Positive effects have been reported, though, by some programs that included parent activities and mass media programming as complements to the school-based intervention (Flay et al., 1987; Pentz et al., 1989a and 1989b). Pentz and colleagues (1989a) included, as part of their intervention program, homework sessions that included interviewing parents and family members about family rules on drugs, techniques to avoid drug use, and how families can counteract media and peer influences.

In a related study, Pentz and associates (1989b) included a parent program that consisted of three to six organizational meetings per year, support activities for the school, and an

educational seminar for all parents. In addition, there was a 1-day workshop each year for school principals, parent group representatives, and student leaders. The training emphasized changing school policy toward prevention education, smoking in and around schools, and providing support skills for parent-child communication and prevention. Thirty-two parents were involved in delivering the parent components of this intervention program.

*Complementary target outcomes.* Reductions in tobacco use have been reported by social influences model programs aimed at general substance use (Ellickson and Bell, 1990; Hansen et al., 1988; Pentz et al., 1989a and 1989b). These studies aimed to reduce adolescents' use of drugs—tobacco, alcohol, and marijuana. In a study that focused on cardiovascular risk factors, Perry and colleagues (1989) reported that, after the fifth year of a school-based health education program, 13.1 percent of the educated group were current smokers, in contrast to 22.7 percent of controls.

In a study by Hansen and coworkers (1988), seventh grade students were provided with social pressure resistance training and were tested prior to training and at 12 and 24 months after training. The initiation of smoking was lower in trained students than among controls: 13.0 and 11.8 percent versus 18.2 and 17.8 percent at 12- and 24-month followup testing. The most significant effect was inhibition of the move to heavier smoking. At the level of five or more cigarettes in the preceding 30 days, the reduction was about two-thirds at 12 months (1.7 versus 5.3 percent for controls) and three-fourths at 24 months (1.4 versus 6.0 percent for controls).

Ellickson and Bell (1990) reported a reduction in the levels of cigarette use that signal heavier smoking. After eighth grade booster lessons, weekly smoking declined in one group by almost 50 percent. Ellickson and Bell suggest that booster lessons are important for maintaining and reinforcing earlier intervention efforts. However, they also suggest that early cigarette smokers "need a more aggressive program than that offered by the social influences model alone."

*Long-term followup.* The only long-term followup studies based on the social influences model reported no program effects enduring beyond high school (e.g., Murray et al., 1989), even if booster sessions were included (Flay et al., 1989). Observed effects were maintained, however, up to 4 years after the conclusion of a program with seventh graders (Murray et al., 1988).

*Current activities.* Researchers at the Oregon Research Institute are involved in a large-scale study of a variation on the social influences model that includes a much stronger

behavior-analytic focus than previous efforts. It differs from many previous efforts in that (1) it is a multiple grade-level intervention; (2) it relies heavily on videotaped material to present information and prompt discussion and training in pressure resistance skills; and (3) it addresses a wider range of risk-taking activities, including alcohol and marijuana use and behaviors such as shoplifting (Biglan et al., 1988). Results at 1 year were encouraging, at least among baseline ever-smokers (Ary et al., 1990).

At the Fred Hutchinson Cancer Research Center in Seattle, researchers are involved in a large-scale study of a social influences model variation. It is delivered annually in grades 3 through 10, is delivered by teachers, and includes a parent component; however, it remains focused solely on tobacco use (A. Peterson, telephone conversation).

Researchers at the New England Research Institute are testing another variation in a Hispanic population. Their intervention focuses on family and advertising issues and includes a video and discussion component designed to involve family members and neighbors in the school-based prevention program (S. McGraw, telephone conversation).

In Minnesota, researchers are testing the effectiveness of statewide legislation designed to encourage schools to adopt social-influences-based programs to prevent tobacco use. The state legislature is providing financial support to schools that adopt such programs, and the research will compare tobacco use by adolescents in Minnesota and in Wisconsin, to determine whether the smoking rate declines in Minnesota as a result of the legislation. The study also includes a randomized trial designed to evaluate the three programs that have been adopted most widely as a result of the 1985 legislation (Murray et al., 1988).

Researchers at the University of Southern California and the University of Chicago are testing a combination of television, family involvement, and school-based programming for their effect on tobacco use (Flay et al., 1988). Researchers in Vermont also are evaluating a school-based versus a school-plus-mass media program (Vorden et al., 1988). Evans and colleagues at the University of Houston are attempting to construct a psychosocial profile of the quickly accelerated heavy smoker relative to the more slowly accelerated moderate or heavy smoker (Evans et al., 1991). They are applying the psychosocial model developed during their work on cigarette smoking to the problem of smokeless tobacco use (Evans and Raines, 1990), with Little League Baseball players as a study population. They are also evaluating the potential contributions to the psychosocial model of factors such as gender

(Evans et al., 1990), ethnicity (Getz and Evans, 1989), self-efficacy (Getz, 1988), and smoking by others, including parents, older siblings, and peers (Cardozo, 1989; Getz et al., 1990).

Evans and associates also have responded to feedback from teachers and administrators who suggest that many useful prevention programs demand more curriculum time and teacher training time than can be allotted. They are developing and testing a compact, 2-week program that requires minimal training and preparation time by classroom teachers. The "Little Red Notebook" program is based on the social influences model and includes exercises in decision-making, role-playing, and rehearsal; self-control methods; reinforcement of pressure resistance skills; and learning to use relevant community service agencies. Each section includes a step-by-step teacher's guide and copy masters for all materials used in the unit. Although more extensive evaluation is needed, there is some evidence of modest results related to decreased use of cigarettes, smokeless tobacco, and alcohol among seventh grade students (Cardozo, 1989; Evans, 1990; Evans et al., 1989).

#### Cognitive Behavioral Model

*Program variations.* Gilchrist and Schinke (1984), in a study with sixth grade students, used self-control skills for smoking prevention and reported that self-control students who reported ever smoking rose only 3.6 percent over baseline after 1 year; control condition students rose 39.3 percent in that same year. These students learned a problem-solving model called SODAS, which instructs students to do the following:

- Stop—think about what they are doing;
- Options—think about their choices;
- Decide—choose the best option;
- Act—make that option happen; and
- Self-praise—reward themselves for making the right decision.

Gilchrist and colleagues (1986) evaluated the self-control process with middle school subjects. At a 15-month followup survey, fewer self-control skills students than controls reported smoking one or more cigarettes for the previous week.

Glynn and coworkers (1985), working with sixth through eighth graders, described the stage model, which states that becoming a smoker is a lengthy, complex process with four stages. The first stage is the preparatory stage, in which adolescents first develop attitudes toward cigarettes and smoking. In the second stage of initiation, the adolescent smokes between one and three cigarettes. In the third stage, becoming a smoker, smoking is irregular and adolescents do not define themselves as smokers. The final stage is maintenance, when regular smoking has begun and the image of a smoker has been

Table 3  
The stage model and smoking motives

Stages	Smoking Motives		
	Social Compliance	Affect Regulation	Self-Definition
Preparatory	Need for social approval	Use of foods, drinks, and over-the-counter medications to regulate emotional state	Need to rebel
Initiation	Peer pressure, social initiation, nonspecific curiosity	Curiosity about mood-altering properties of cigarettes	Need for impression management (i.e., how one appears to others)
Becoming	Continuing social influences	Positive evaluation of sensations produced by smoking	Is an instant adopter and skips this stage
Maintenance	Continuing social influences, positive evaluation of sensations produced by smoking	Establishment of a link between smoking and affective state of sensations produced by smoking	Satisfaction with projected image, positive evaluation

Adapted from Glynn et al. (1985).

adopted. Table 3 shows how the stage model depicts factors that influence adolescents at different smoking stages.

Schinke and associates (1985a) used graduate social workers to provide skills intervention and information intervention to sixth graders. At 6, 12, and 24 months after the intervention, the skills students had a lower percentage of smoking than did the information-only and the control students. A four-step chain in the skill-building interventions—stop, think, decide, and act—was used by Schinke and coworkers (1985b).

Schinke and Gilchrist (1984, 1985, and 1986) have conducted several studies that were led by project staff using the cognitive behavioral technique. In 1984, the investigators reported that students in the skills-building condition, when

compared with students in an attitude modification condition or with controls, had larger gains at followup testing for identifying healthy solutions, encouraging nonsmoking, and anticipating negative consequences of tobacco use. Pentz (1983) reported positive results with a combination of teacher and peer leader administration techniques.

Beneficial effects were reported when the program was delivered to elementary school students, rather than the usual delivery of psychosocial prevention programs to seventh or eighth grade students (Gilchrist and Schinke, 1984; Gilchrist et al., 1986; Schinke et al., 1985a, 1985b, 1986a, 1986b, and 1988a; Schinke and Gilchrist, 1984, 1985, and 1986). Schinke and colleagues (1986b), working with sixth graders, taught problem-solving, self-instruction, and communication skills. When compared with students in a health education program, students in this study had better knowledge scores and non-smoking intentions. Schinke and coworkers (1986a and 1988a) reported that, in a study that began with students in the fifth and sixth grades, students showed lower rates for both smoking and smokeless tobacco use.

Native American adolescents are a particularly vulnerable population for abuse of substances, including tobacco, according to results obtained by Schinke and colleagues (1988b). At 6-month followup, the treatment group reported less use of both smoked and smokeless tobacco during the previous 14 days. However, because of the small number of subjects ( $n = 61$ ) and the short period of followup, the authors advise a cautious interpretation of their results.

Failures to duplicate results of earlier studies have been reported for studies with high-risk girls (Gilchrist et al., 1989). Gilchrist and associates reported the following data for high- and low-risk girls and boys at a 24-month followup survey. The percentage of weekly smokers in the high-risk girls category was 9.1 percent; for low-risk girls, weekly smokers were 3.6 percent; for high-risk boys, 7.3 percent; and for low-risk boys, 4.8 percent. The weekly smoking rate for high-risk girls was significantly higher than for any other intervention category and was similar to the high-risk girls in the control group (10.2 percent reporting weekly smoking).

Gilchrist and associates (1989) suggest that females begin and continue smoking for different reasons than do males. Young female smokers tend to be more socially competent and self-confident than their male counterparts and do not smoke for social coping purposes or to demonstrate assertiveness. Therefore, teaching refusal and social competence skills may be less useful and relevant for females than for males, and thus have less effect.

A more appropriate technique may require less attention to skills training and more to self-definition and self-expression. In addition, tension reduction and information on weight control methods, because smoking is perceived to be valuable for weight control, could prove to be more relevant to young female smokers (Gilchrist et al., 1989).

**Complementary delivery channels.** The programs based on the cognitive behavioral model have been exclusively school-based. Thus, there are no reports of investigation of complementary channels for program delivery.

**Complementary target outcomes.** Positive effects of reducing tobacco use have been reported by programs aimed at general substance use (Pentz, 1983; Schinke et al., 1988b). Such programs have not targeted other health outcomes, however.

**Long-term followup.** There have been no published reports from followup studies beyond 2 years for programs based on the cognitive behavioral model.

**Current activities.** Researchers at Columbia University are testing a variation of the cognitive behavioral model in a high-risk population (S. Schinke, telephone conversation). Adolescents at high risk for smoking often have been unaffected by intervention efforts in the past, and this remains an important area for research. The Columbia group employs the basic cognitive behavioral model but has modified the role models and scenarios to be more appropriate for high-risk youth. The investigators also have added a component to address values on deviance.

#### Life Skills Model

**Program variations.** Positive effects have been reported when the life skills program was delivered by the project staff (Tell et al., 1984), by teachers (Botvin et al., 1983, 1989a, and 1989b; Bush et al., 1989; Vartiainen et al., 1983, 1986, and 1990; Walter et al., 1986, 1988, and 1989), and by a combination of teachers or staff and peer leaders (Botvin et al., 1984; Tell et al., 1984; Vartiainen et al., 1983, 1986, and 1990). The smoking prevention curriculum for one cohort of the study by Tell and coworkers is shown in Table 4. Tell and associates provided this social skills training in a 10-session curriculum that began in September 1979 and ended in February 1981.

Botvin and colleagues (1989a) used a psychosocial approach with black junior high students. The study used 12 intervention sessions of 45 minutes each. In addition, an internal review committee of black researchers (a psychologist and two health educators) reviewed the material to make certain that the language, reading level, examples, and underlying concepts were appropriate for black youth. An external review group of black seventh grade students and outside

Table 4  
A program variation of the life skills model

Session	Topics
September 1979	Personal commitment and discussion of social pressures.
September 1979	Pressure resistance training. Student-led role-playing.
November 1979	Social pressures and arguments against smoking.
March 1980	Coping with social anxiety.
May 1980	Pressure resistance training. Student-led talks about the harmful effects of smoking.
October 1980	Smoking: self-pollution and waste of resources. Smoking as a form of self-pollution and growing tobacco as a waste of agricultural resources were discussed.
November 1980	Passive smoking. Second-hand smoke, parental smoking, peer pressure at youth clubs were discussed.
December 1980	Long-term effects of smoking and marketing of tobacco. Cancer and cardiovascular diseases relating to smoking and comparison of selling tobacco in Third World countries versus selling it in Norway were discussed.
January 1981	Social and health aspects of smoking.
February 1981	It is your choice. A film on alcohol consumption was shown, and drinking and parallel smoking pressures were discussed.

Adapted from Tell et al. (1984). Sessions were 45 minutes in length.

experts with expertise with black youth was also formed. The main purpose of the study was to explore the feasibility of applying the life skills training model, previously used with middle-class white youth, to urban black youth. The overall rate of smoking during the most recent month of the study was down by 56 percent, although regular smoking did not appear to be affected.

Bush and coworkers (1989) identified problems that may affect most intervention studies for urban black youth: meeting the parental consent requirement, lack of true controls, variations in teacher effectiveness, frequent student transfers, isolation of the program within schools, data collection procedures, and lack of teacher support for the program. For example, at the seventh grade level, all of the health teachers were smokers, and their effectiveness therefore came into question. In addition, it was difficult for the research team to judge the effect of teachers as role models because of incomplete attendance at teacher training sessions and because there was some question about whether the teachers adhered to the curriculum.

Failures to duplicate results have been reported for studies with teacher-administered life skills programs (Botvin et al., 1984), particularly when the teachers received inadequate training (Botvin et al., 1989b; Tortu and Botvin, 1989). Tortu and Botvin (1989) cautioned that poor implementation can be misinterpreted as program failure. Therefore, to help ensure proper implementation of programs, effective teacher training must accompany teacher-administered programs. The training must include the theory underlying the program, demonstrations of skills needed to administer the program, practice of the new skills, and feedback and coaching from project staff. The social skills programs stress that students learn decision-making skills, assertiveness, and anxiety reduction. These skills require classroom techniques that differ from traditional teaching methods, for example, the practice of adolescent skills through role-playing (Tortu and Botvin, 1989).

Additional benefits have been reported when the initial intervention is followed by a booster program. Botvin et al. (1983), in an intervention program with seventh grade students, reported 60 percent fewer new regular smokers than when the same intervention program was used without booster sessions. Furthermore, the eight booster sessions, which took place in the second year of the program, resulted in 87 percent less regular new smoking than among controls.

Positive effects have been seen also when the intervention continues over several years (Bush et al., 1989; Tell et al. 1984; Walter et al., 1986, 1988, and 1989). Walter and associates began a study of coronary heart disease prevention with a baseline population of fourth graders. Each year from the fourth to the ninth grade, students received a teacher-delivered curriculum that included material designed to prevent cigarette smoking. After 6 years, the rate of initiation of cigarette smoking was significantly less (by 73 percent) than in the non-intervention schools.

By comparison, in a condensed timeframe, Botvin and colleagues (1983) conducted the life skills training program on consecutive days and completed the program in about 1 month, in addition to carrying out the usual practice of weekly sessions delivered over the course of a semester or a full school year. They reported that smoking initiation rates were significantly lower in the intensive program than among control students (who received no special prevention activities), according to monthly, weekly, and daily measures.

*Complementary delivery channels.* An intervention program that was delivered within a broad-based and communitywide heart disease prevention program produced positive results (Vartiainen et al., 1983, 1986, and 1990). The North Karelia Youth Project attempted to reduce the factors associated with cardiovascular disease risk, including smoking, serum cholesterol, dietary habits, and blood pressure. The program was begun with a group of students who were 13 years old. In two schools there was an intensive intervention program and in nine others, less intensive intervention; the balance of schools in the community served as controls. The intervention strategy was applied over a 2-year period.

In the first followup survey (Vartiainen et al., 1983), 21 percent of the students were smoking at least monthly in the intensive intervention schools, 19 percent in the less intensive intervention schools, and 29 percent in the control schools. At the second followup survey, these figures were 24, 22, and 34 percent, respectively. Four years after the program's start, the reported rates were 27 percent for the intensive intervention group, 26 percent for the less intensive intervention group, and 37 percent for the control group (Vartiainen et al., 1986). Eight-year followup results indicated that some of the intervention effect had been lost. Preventive effects seemed to have been beneficial only for those who were nonsmokers when the program began.

*Complementary target outcomes.* Effects that reflect reduced use of tobacco have been reported by programs based on the life skills model and directed to general substance use (Botvin et al., 1984) as well as those that aimed at cardiovascular risk factors (Tell et al., 1984; Vartiainen et al., 1983, 1986, and 1990; Walter et al., 1986, 1988, and 1989). Details of these studies are mentioned in previous sections.

*Long-term followup.* Two studies reported followup for more than 2 years beyond the initial life skills intervention. Walter and colleagues (1988 and 1989) reported positive effects at the end of the ninth grade, in a study that included interventions each year from grades 4 through 9. Vartiainen (1986 and 1990) reported positive effects 2 and 6 years after a 2-year intervention was delivered to students in grades 7 through 9.

# CLINICAL APPROACH TO SMOKING CONTROL Historical Trends

*Current activities.* At the American Health Foundation, researchers are examining whether the comprehensive life skills model aimed broadly at cardiovascular risk reduction will be more effective for preventing tobacco use than will the targeted application of only those components aimed at substance use (M. Orlandi, telephone conversation). Researchers at Cornell University are exploring even broader applications of the life skills model that would seek to improve skills related to future employment or early sexual behavior (G. Botvin, telephone conversation).

The major efforts in smoking control have been aimed at the individual smoker—trying to motivate smokers to quit and help them to do so. Such assistance has included formal cessation programs, usually delivered in small groups, and one-to-one direct advice or counseling from a health care provider. More recently, pharmacologic adjuncts (Grabowski and Hall, 1985) have been added to the treatment mix in both settings. This section briefly reviews the research on the effectiveness of clinical approaches and appraises their potential contribution to a comprehensive program to reduce tobacco use.

Research on smoking cessation was initially driven by a clinical perspective. The aim was to develop effective methods that cessation clinics could use with motivated smokers who referred themselves for "treatment," or that physicians and other health providers could use with their patients. Serious smoking cessation research and service programs have a rather short history, only about 30 years. Even early on there were proponents of both pharmacological approaches and educational-psychological approaches. The early pharmacological strategies were rather primitive by current standards. Although the role of nicotine in the maintenance and cessation of smoking was poorly understood, the notion of replacing or mimicking nicotine's action was seen as plausible. Much of the early pharmacological research focused on lobeline, presented in over-the-counter products like Bantron and occasionally by injection. Placebo studies yielded fairly convincing demonstrations of lobeline's lack of efficacy (Kozlowski, 1984).

Cigarette smoking quickly attracted the attention of workers in behavior therapy. Behavioral approaches to smoking cessation tended to reflect current practices or the zeitgeist in behavior therapy rather than deriving from an analysis or understanding of smoking behavior (Lichtenstein, 1982). Smoking was considered to be a learned habit; pharmacological and biobehavioral processes were neglected. Earlier behavioral approaches to smoking featured conditioning methods followed by self-control strategies and tactics that represented behavioral thinking in the 1960's and early 1970's. Behavioral approaches in the 1980's had major cognitive components,

reflecting the interest in cognitive behavioral strategies. Within this general trend, however, behavioral workers generally maintained an empirical attitude and became increasingly sensitive to the developing body of knowledge about both psychosocial and pharmacological processes in smoking behavior. For example, behavioral researchers evolved nicotine-fading (Fox and Brown, 1979) or brand-switching strategies to deal with pharmacological processes and tended to be sympathetic to nicotine chewing gum as an adjunct to—or even a major component of—cessation programs (e.g., Goldstein et al., 1989).

Another trend in the late 1970's and 1980's was the shift in emphasis from smoking cessation to maintaining abstinence and preventing relapse. The change was sparked by repeated observations that most participants in cessation programs either quit or greatly reduce their smoking, but the majority subsequently relapse—most of them soon after the program ends. Although early programs tended to focus on smoking cessation by the end of the program, considerable program time is now devoted to relapse prevention. Marlatt and Gordon's (1985) book on relapse prevention epitomized this trend. Both behavioral and pharmacological strategies are employed to achieve maintenance and relapse prevention. Smoking cessation now is recognized as a process that encompasses several identifiable stages—from precontemplation to maintenance or relapse (Prochaska et al., 1988). The importance of tailoring cessation materials to the smoker's stage of readiness to change is increasingly recognized, although not yet empirically supported.

Two other noteworthy trends in clinical intervention are interrelated. One is the renewed and vigorous interest in pharmacologic intervention, especially nicotine replacement therapies (Grabowski and Hall, 1985). This thrust is fueled by advances in knowledge about the critical role of nicotine in maintaining smoking behavior and in the quitting or relapse process (US DHHS, 1988), which have paved the way to growing literature on the effectiveness of nicotine polacrilex—both when used with relatively minimal advice and support and when combined with behavioral counseling and group support. The final trend noted is toward briefer clinical interventions delivered in the context of usual medical care (Glynn, 1988; Ockene, 1987a; Russell et al., 1983). This strategy capitalizes on the credibility of physicians (American Cancer Society, 1977), the teachable moments in medical transactions (Vogt et al., 1989), and the possibility for physicians to use pharmacological adjuncts, a familiar treatment modality.

## Effectiveness of Different Methods

There are different cessation methods, and it is possible to categorize them in different ways. Schwartz (1987) lists 21 different approaches in his summary table. With the exception of pharmacological strategies and physician advice or counseling approaches—where there has been much activity in the last 5 years—Schwartz's review of specific clinical cessation methods remains valid.

It is also possible to organize cessation methods into general strategies, for example, self-management strategies, aversive strategies, pharmacological strategies, relapse prevention strategies, combined behavioral-pharmacological approaches, and multicomponent strategies (Kamarck and Lichtenstein, 1988). In fact, nearly all clinical interventions are now multicomponent to a significant degree. Table 5, adapted from Lichtenstein and Mermelstein (1984), lists and briefly describes the typical elements in a multicomponent program, which are organized around three program phases: preparation for quitting, initial quitting, and the maintenance of quitting. No one program is likely to use all of these elements. Given the large number of different kinds of studies, the fact that some methods have been evaluated extensively and some very little, and the differences in evaluation criteria, it is difficult to identify the most effective interventions. However, the following conclusions seem defensible.

The research literature generally indicates that more intensive and extensive interventions are more effective than single-strategy or single-session methods. For example, single-strategy interventions have yielded weak results, whereas multicomponent programs (e.g., Lando, 1986; Ockene et al., 1982) have shown the highest quit rates. Good multicomponent programs can yield long-term (1-year) confirmed quit rates of 30 to 40 percent. The intensity of the intervention or number of contacts also seems important. For example, Lando's (1986) 15-session program is among the most effective intervention reported, and the high quit rates reported by Ockene et al. (1982) for the Multiple Risk Factor Intervention Trial are consistent with that conclusion. With respect to physician advice, a meta-analysis reveals that more frequent contacts are associated with higher quit rates (Kottke et al., 1988). Some research in the self-help or minimal assistance realm also indicates that additional prompts, for example, supportive phone calls, enhance effectiveness (Glynn et al., 1990; Orleans et al., 1988).

It is difficult to empirically determine and demonstrate the specific efficacious elements of multicomponent programs. There is undoubtedly a large nonspecific effect in smoking cessation programs. The commitment to attend regular sessions, expectations of help, group or counselor support, and engagement with therapeutic activities (e.g., homework assignments)

Table 5  
Methods used by cessation programs

Program Phase	Typical Elements
Preparation	<p>Mobilizing client motivation and commitment</p> <ul style="list-style-type: none"> <li>• Deposits contingent on attendance</li> <li>• Review reasons for quitting and benefits of stopping</li> </ul> <p>Self-monitoring; increase awareness of smoking patterns by keeping records*</p> <p>Setting target quit date 1 to 3 weeks ahead*</p> <p>Self-management training</p> <ul style="list-style-type: none"> <li>• Use self-monitoring to identify typical cues for smoking</li> <li>• Identifying substitutes for smoking and alternative non-smoking behaviors*</li> <li>• Stress management training; relaxation or exercise</li> </ul>
Quitting (usually one of typical elements listed)	<p>Aversive strategies</p> <ul style="list-style-type: none"> <li>• Pairing smoking with electric shock</li> <li>• Rapid smoking—inhaling every 6 to 8 seconds in the clinic until nausea is imminent or saturation—doubling or tripling at-home smoking</li> </ul> <p>Nonaversive strategies</p> <ul style="list-style-type: none"> <li>• Nicotine fading (switching successively to brands with increasingly lower nicotine content)</li> <li>• Target date contract</li> </ul> <p>Pharmacological—Using nicotine replacement methods (e.g., gum, patches) as a temporary substitute</p>
Maintenance	<p>Followup sessions or phone calls</p> <p>Coping skills training*</p> <ul style="list-style-type: none"> <li>• Transfer self-management skills to maintenance by avoiding cues to smoke and using substitutes (e.g., cinnamon sticks, water, deep breathing)</li> <li>• Cognitive behavioral coping: anticipating high-risk situations; planning coping strategies</li> <li>• Coping with slips or lapses; learning from mistakes</li> </ul> <p>Social support</p> <ul style="list-style-type: none"> <li>• Buddy systems</li> <li>• Involving significant others (e.g., spouse)</li> </ul> <p>Pharmacological—Continuing to use nicotine replacement to cope with withdrawal</p>

\*Found in most programs



are known to have powerful effects on any behavior problem, including smoking. Attempts at component analysis—determining efficacious and nonefficacious elements—have generally failed (e.g., Lando, 1986); such studies are markedly lacking in statistical power (Glasgow and Lichtenstein, 1987). Similarly, attempts to identify the value of individual components by adding a single *behavioral* strategy such as spouse or partner support to a basic multicomponent program have also been unsuccessful (e.g., Lichtenstein et al., 1986).

The addition of pharmacological adjuncts, notably nicotine chewing gum, to multicomponent cessation programs yields a more consistent and positive picture. Combining nicotine gum and behavioral counseling tends to produce better results than either approach by itself (Goldstein et al., 1989; Hall et al., 1987; Killen et al., 1984).

Both clinical experience and research support the importance of focusing attention on the maintenance or relapse prevention phase of intervention (see Table 5). Although there are some notable examples of the effectiveness of relapse prevention components (Hall et al., 1984; Stevens and Hollis, 1989), there are as many failures (for a summary, see Glasgow and Lichtenstein, 1987). Nevertheless, there remains a consensus that attention to relapse prevention is important. It is plausible, however, that environmental factors, including other people's smoking, are critical to maintenance (Glasgow and Lichtenstein, 1987).

For the individual smoker, conscientious attendance at a multicomponent, small-group, cessation program (including nicotine replacement strategies) is the best possible move toward becoming an ex-smoker. Such a program is likely to produce a 30 percent quit rate at 1-year followup. Although far from the sure thing advertised by some proprietary programs and private practice providers, this is a good result compared with a single attempt at self-quitting (Cohen et al., 1989) or even quitting with the advice and assistance (e.g., prescription of a nicotine chewing gum) of a primary care physician (Glynn, 1988).

#### Cessation Clinics

*Limitations of cessation clinics.* Two extensively researched cessation programs illustrate the strengths and weaknesses of the cessation clinic approach. In the 1970's, many programs employed rapid smoking (Lichtenstein et al., 1973; Schmahl et al., 1972), typically accompanied by considerable behavioral counseling and support. Rapid smoking is an aversive procedure wherein the smoker puffs and inhales every 6 to 8 seconds until nausea begins. It is the most frequently studied clinical strategy, accounting for 49 of the 416 trials summarized in Schwartz's comprehensive summary (1987), and its close cousins—satiation

and regular-paced aversive smoking—account for another 39 trials. Quit rates, although quite variable, are often 30 percent or more at followup, which is considered good for cessation programs.

However, the procedure is used sparingly today for several reasons. The accelerated nicotine intake from rapid smoking requires screening and safeguards (Lichtenstein and Glasgow, 1977) and leads to the exclusion of many patients who need assistance. The method also requires close supervision either in one-to-one or in small group settings to monitor possible side effects. Concern about risks with the use of aversive methods makes many providers and consumers wary. Rapid smoking remains a reasonably powerful strategy, but it has a narrow range of application (Lichtenstein, 1982).

The second multicomponent program probably represents the best that formal cessation programs have to offer while again illustrating some inherent limitations. Over a span of 15 years, a multicomponent, nonaversive, 8-week, 15-session program was empirically developed and evaluated (Lando, 1986). (The program originally included satiation smoking—doubling or tripling at-home smoking for a specific period—a cousin of rapid smoking that provokes concerns about similar risk and screening; however, recent research indicates that nicotine fading effectively replaces satiation.) One-year abstinence rates were consistently 30 percent or better. Most importantly, the research team developed a partnership with the Iowa Lung Association, in which association volunteers were trained to deliver the program while the research team continued evaluation and monitoring. The Iowa Lung Association offered nearly 70 such clinics in 1 year (Lando et al., 1989). Thus, an empirically validated cessation clinic was given away to the public sector and disseminated at low cost statewide. However, the intensive nature of the program—15 sessions of 1 hour each—plus the need for trained volunteer leaders limit its applicability. Most smokers will not or cannot make such a behavioral commitment to any cessation clinic.

*Acceptance of cessation clinics.* Cessation clinics are often the initial strategy of antismoking efforts, and they are a tangible resource and an important component of any comprehensive program. It is worthwhile to encourage smokers to attend such clinics, and most cities have clinics that are underused (e.g., offered through local hospitals); however, cessation clinics are not accepted by and will not reach the great majority of smokers. There are several lines of evidence that support this assertion. (1) The great majority of ex-smokers quit or try to quit without the aid of formal programs (Flore et al., 1990; US DHHS, 1982). (2) Data from surveys indicate that

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most smokers prefer self-help or other assistance (e.g., from physicians) in preference to cessation clinics (Gallup Opinion Index, 1974; Owen and Davies, 1990; Schwartz and Dubitzky, 1967). (3) The demand for cessation clinics does not appear great, judging from anecdotal reports of various program recruitment efforts. According to one market research survey, about 1.7 million smokers, a little more than 3 percent of the smoking population, attended some kind of cessation clinic in 1988 (Pierce, 1990). Also, even if the demand increased, there would be many places, for example, rural areas and inner cities, where the supply of cessation clinics would always be inadequate. (4) Stop-smoking programs have not been nearly as successful commercially as their weight-loss counterparts. Schwartz (1987) notes that three national programs established between 1968 and 1971—Smoke Watchers, SmokEnders, and Schick—had reduced operations by 1985.

Clinical intervention through health providers offers greater potential to reach smokers. It is estimated that physicians have contact with at least 70 percent of all smokers each year (Ockene, 1987a) and that approximately 38 million of the 53 million adult smokers in the United States could be reached by physicians in the normal course of their medical care. Physicians are seen as a credible source of cessation advice (American Cancer Society, 1977). At the time of a consultation with a physician, patients are sensitized to their health and vulnerability, thus creating a teachable moment that could be used by health providers (Vogt et al., 1989). One NIH publication refers to these as "clinical opportunities" for smoking intervention and provides materials to promote physician involvement in smoking cessation (US DHHS, 1986).

These considerations have given rise to a sizeable body of literature on the effects of physician advice (see reviews by Glynn, 1988; Ockene, 1987b; Pederson, 1982). Compliance with physician advice to quit smoking has been addressed in more than 40 studies. Although the studies vary considerably in focus and methodological rigor, the evidence from randomized trials suggests that physicians who intervene with smokers have a small but measurable impact on public health. Studies of the effectiveness of physician smoking interventions indicate that advice or brief counseling alone can result in patient quit rates of 5 to 10 percent, an outcome of enormous public health significance (US DHHS, 1986). Furthermore, the data suggest that even higher cessation rates can be achieved when physician-patient contacts are more intensive and frequent and when nicotine gum is used also (Fagerstrom, 1984; Glynn, 1988; Wilson et al., 1987). As with most interventions, short-term (1- to 3-month) quit rates tend to be higher; by 1-year followup, significant relapse has occurred.

Importance of  
Clinical  
Interventions

One cautionary note here is that most placebo-controlled trials indicate that nicotine gum is not effective when prescribed in routine outpatient settings (Hughes et al., 1989; Jamrozik et al., 1984; Lam et al., 1987). It is possible that instruction in the proper use of the gum (S.R. Cummings et al., 1988) has been insufficient. Nicotine gum is effective, however, if accompanied by counseling and support and if careful instructions for using the gum are given (Glynn, 1988). Nicotine replacement via transdermal patches is another promising strategy that both physicians and patients may find convenient. Preliminary data from patch trials are promising.

Surveys indicate that most physicians accept responsibility for dispensing cessation advice (Wechsler et al., 1983) and report that they do dispense such advice (Wechsler et al., 1983; Wells et al., 1986). Although some survey data reflect physicians' pessimism about their efficacy and indicate financial and organizational obstacles (Orleans et al., 1985), several studies have demonstrated that physicians can be motivated to deliver a cessation protocol, at least during the course of a study (e.g., Fagerstrom, 1984; Janz et al., 1987; Wilson et al., 1987). Whether the majority of physicians can be induced to advise or counsel smokers consistently when not motivated and monitored by a research staff remains to be demonstrated. Nevertheless, from a public health perspective, physician interventions have the potential to reach large numbers of smokers.

Clinical cessation interventions have made substantial contributions to antismoking efforts. Although it is difficult to provide accurate quantitative estimates, cessation clinics have, over the past 25 years, helped several million smokers quit. The American Cancer Society has sponsored cessation clinics based on its own program and materials; the American Lung Association has also sponsored clinics on a more limited basis. Evaluation of these programs (Schwartz, 1987) indicates 1-year quit rates averaging about 20 to 25 percent.

Hospitals, health plans, and health departments are offering cessation programs in increasing numbers. Schwartz (1987) reported a major increase in these programs from 1980 to 1985, and the trend appears to continue. At least two standardized, commercial programs, SmokeLess and Smoke Stoppers, are now licensed to hospitals that offer the services to the community. An estimated 600,000 smokers have completed the SmokEnders program (US DHHS, 1989). Adding in the other major commercial programs, Schick and Smoke Watchers, along with the numerous private practitioners who work with smokers—psychologists, psychiatrists, and hypnotherapists—one can see the significant aggregate impact of such services. They continue to provide a resource for motivated smokers who are unable to quit without help.

Besides individual and group cessation services, clinical interventions in the context of medical care probably have a significant impact on smoking cessation. Many of the self-quitters noted in the 1982 Surgeon General's Report may have been prompted by a physician's advice or warning. National surveys indicate that most physicians accept responsibility for helping patients stop smoking and many provide advice (Ockene, 1987a), although far fewer provide tangible assistance. Survey data from both America (Ockene et al., 1990-1991) and Australia (Owen and Davies, 1990) indicate that smokers see physicians as a major resource.

Another indicator of medical provider impact on smoking cessation comes from prescription sales of nicotine-containing chewing gum. Since nicotine gum was introduced in 1984, an estimated 4 to 6 million smokers, according to one source, have received prescriptions for it (US DHHS, 1989). An industry spokesperson places the estimated number at 8 million and estimates that 95 percent of primary care physicians have prescribed nicotine polacrilex (Nicorette) (Rongey, 1990). Surveys indicate that about two-thirds of these prescriptions are patient initiated. These data also reflect the potential for health care providers to reach far more smokers than can cessation clinics. The availability of nicotine gum and other pharmacologic adjuncts that may be developed can prompt physicians and patients to engage in quitting attempts.

Because clinical interventions reach moderate numbers of smokers and because they are a resource and a source of hope for many dependent smokers, these interventions must be an integral part of any comprehensive plan. Policy and other environmental strategies may shift social norms and change attitudes toward smoking such that some people will quit (or not start) with their own resources; however, many people, especially heavy smokers, will need the assistance of some kind of clinical service. Most smokers will not require a full-service cessation clinic but could profit from advice and support (e.g., a prescription) from a health care provider, a worksite incentive program, or some measure of individual prompting and assistance.

Clinical interventions also have a subtle but important by-product. They help to develop and maintain experts on smoking behavior, who in turn may have influence on public opinion. This influence operates at both local and national levels. A comprehensive community program needs credible spokespersons, and a physician who actively advises and counsels smoking patients becomes such a resource. Similarly, leaders of cessation clinics also develop expertise and credibility as spokespersons.

There is a final contribution of the clinical approach that may be as important as the number of quitters produced. Clinical interventions have been the vehicle for developing knowledge about the process of quitting, understanding the nature of tobacco addiction, and developing useful quitting strategies. For example, cessation clinics have provided information about the effectiveness of nicotine chewing gum (e.g., Russell et al., 1983), the efficacy of combining behavioral and pharmacological strategies (Killen et al., 1990), and the usefulness of nicotine fading or brand switching (Fox and Brown, 1979). Most of the strategies and tactics embodied in the self-help materials described below were developed in cessation clinics. As new knowledge about smoking develops and spawns new intervention technologies (e.g., nicotine patches), cessation clinics and health providers will provide settings within which they may be evaluated and refined.

#### SELF-HELP APPROACHES

Most of the estimated 37 million people who have stopped smoking since the Surgeon General's first report on smoking and health have done so without the aid of formal cessation programs (Fiore et al., 1990). Survey data indicate that about one-third of current smokers made a quit attempt within the last year (Harris, 1980), and they express a preference for quitting without the aid of formal cessation programs (Gallup Opinion Index, 1974; Owen and Davies, 1990; Schwartz and Dubitsky, 1967). In recent years, growing recognition of the importance of unaided quitting (US DHHS, 1982) and the relative limitations of clinic-based cessation programs in dealing with what is a public health problem (Epstein et al., 1989) have given rise to substantial literature on unaided or minimally assisted quitting.

Emerging studies suggest that unaided quitting is not a unitary concept, but rather one that requires definition (Lichtenstein and Cohen, 1990). There is no solid line separating clinical cessation from self-help efforts. It is probably more useful to construe a continuum ranging from an intensive, structured clinic to a smoker's making a New Year's resolution and quitting without any materials whatsoever. Self-help studies have reported on the effects of materials received through the mail (Jeffrey et al., 1982), community-wide quitting contests (Glasgow et al., 1985), New Year's resolution quitting (Gritz et al., 1988; Marlatt et al., 1988), persons requesting self-help manuals (K.M. Cummings et al., 1988; Davis et al., 1984), and computer-assisted self-quitting programs (Prue et al., 1990). Unaided quitting efforts have two major defining characteristics: first, the smoker initiates the self-quitting attempt on his or her own initiative or with minimal prompting from a health care provider or health educator; and second, the effort involves no face-to-face counseling or advice from a health professional.

### Effectiveness of Self-Help Efforts

Not surprisingly, unaided quitting tends to result in somewhat lower quit rates than those achieved with clinical interventions, although the differences are not large. Point-prevalence quit rates at 1-year followup tend to be in the 10 to 20 percent range (Cohen et al., 1989; Davis et al., 1984; Schwartz, 1987). For continuous quitting, a less frequent but more conservative criterion is used; then, abstinence rates at 1-year followup tend to be in the range of 3 to 5 percent (Cohen et al., 1989; Davis et al., 1984). Cohen and colleagues (1989) included several samples from different areas of the United States and found no differences at 12-month followup between quitters receiving materials (self-help booklets) from the investigator and those who quit completely on their own. Although self-quitting rates are lower than those for more intensive interventions, their cost-effectiveness is probably higher since there is little or no professional time involved (Epstein et al., 1989).

Self-help materials are often used in concert with media or community programs. The media may be used to promote self-help products, as when a volunteer organization uses public service spots to encourage viewers to request a pamphlet or when proprietary companies use media to advertise products such as LifeSign or Cigarrest. The use of telephone cessation hotlines also can be increased through publicity (Ossip-Klein et al., 1984).

Community campaigns have typically made extensive use of self-help approaches. One particularly effective method is a mediated, community-wide, cessation program. Through publicity about a quitting program via television or newspapers, significant numbers of smokers can be induced to make serious quitting attempts (Cummings et al., 1987). Quitting strategies may be provided to participants also through written self-help materials, and prizes for selected quitters (via lottery) may be offered. Self-help materials can also be joined with nicotine polacrilex to increase quit rates (Fortmann et al., 1988; Killen et al., 1990). Finally, physicians prescribing nicotine gum (or pharmacists dispensing it) can provide written materials to help patients deal with the behavioral aspects of smoking.

### Acceptability of Self-Quitting

Surveys have found that most smokers prefer indirect or self-help methods rather than formal cessation clinics (Gallup Opinion Index, 1974; Schwartz and Dubitsky, 1967). A recent probability sample from Australia (Owen and Davies, 1990) confirms the lack of interest in cessation groups (6.7 percent) but found considerable interest in "a program through your doctor" (23.7 percent) and "a program through [another] health professional" (12.5 percent). Unpublished survey data from the Community Intervention Trial for Smoking Cessation

also suggest strong interest in assistance from physicians. This shift toward an interest in more direct or personalized cessation services may be an Australian phenomenon; however, it also may reflect historical changes in smokers. Today's smokers may better recognize their dependency and need for external assistance.

Nevertheless, there is a considerable consumer demand for take-home services or aids. Although no smoking cessation book has reached the nonfiction best seller lists—as is common for diet books—the public consumes millions of free brochures and pamphlets published by the Federal Government and the major voluntary organizations. One Government agency reported distributing over 2.5 million smoking-related items in 1989. It has been estimated that Government and voluntary agencies combined produce 100 new smoking and health items each year. The brisk market for commercial products such as Cigarrest and LifeSign also attests to the public's willingness to try promising methods in the privacy of their own homes and offices.

### Importance of Self-Quitting

Several considerations make self-help materials a critical element in any comprehensive smoking intervention. Their acceptance by many smokers is a major factor; another factor is their availability, as Government agencies and major voluntary organizations have already created many useful products. For the voluntary organizations, both their mission and their self-interest dictate that they create, update, and disseminate good materials bearing their names; a shortage of good self-help materials is not likely. The great majority of these self-help materials either are free or cost very little. The problem is disseminating or deploying them effectively. A parallel motive drives the private sector; as long as there is the potential to make a profit, self-help products such as LifeSign and Cigarrest will be marketed.

Because self-help materials are acceptable to many smokers, are relatively inexpensive, and can be distributed in settings where smokers naturally are found (medical offices, worksites, stores), they have the potential to reach many more smokers than do clinical interventions. They also offer the opportunity to tailor messages to particular subgroups of smokers in a cost-effective way. Market segmentation can focus on smokers along the lifespan trajectory, such as written materials aimed specifically at adolescents, pregnant women, or mothers of newborns. Alternatively, self-help materials can be focused on various demographic groups or on smokers at different points on the readiness-to-change continuum (Prochaska et al., 1988).

Finally, the presence and publicizing of both nonprofit and proprietary self-help materials increase public awareness of the smoking problem. For example, media advertising and store displays of commercial materials (e.g., LifeSign, Cigarrest) contribute to an environment that reflects public concern about smoking and support for those trying to quit. In summary, specific self-help materials or methods are likely to have only weak effects by themselves, but in combination with media or community programs, they can reach various populations of smokers and are a critical part of any comprehensive smoking reduction program.

## CONCLUSIONS

- Public information campaigns have been successful in increasing awareness of the disease risks associated with smoking and have motivated some smokers to quit; however, they do not create substantial change in the behavior of regular smokers when used as an isolated smoking control strategy.
- School-based education methods have been demonstrated to reduce the prevalence of smoking for several years among adolescents receiving the curricula. This benefit in reduced or delayed initiation of smoking has been demonstrated for programs that treat smoking in conjunction with other drug-use behavior as well as for curricula that deal with smoking alone.
- The best school-based curricula include skills training in dealing with the social environment, and programs that include parent and community involvement are more successful than those that do not.
- Formal cessation clinics have the highest rate of successful long-term cessation of any smoking control strategy, but only a limited number of smokers will participate in such programs.
- Formal cessation clinics, brief personalized interventions by health providers, and the gamut of self-help materials constitute a continuum of services aimed at the individual smoker. When properly integrated in community programs such as the Community Intervention Trial for Smoking Cessation (Pechacek, 1987), they complement one another and offer attractive options for smokers with varying needs and interests.

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## Chapter 5

# Approaches Directed to the Social Environment

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## Chapter 5

# Approaches Directed to the Social Environment

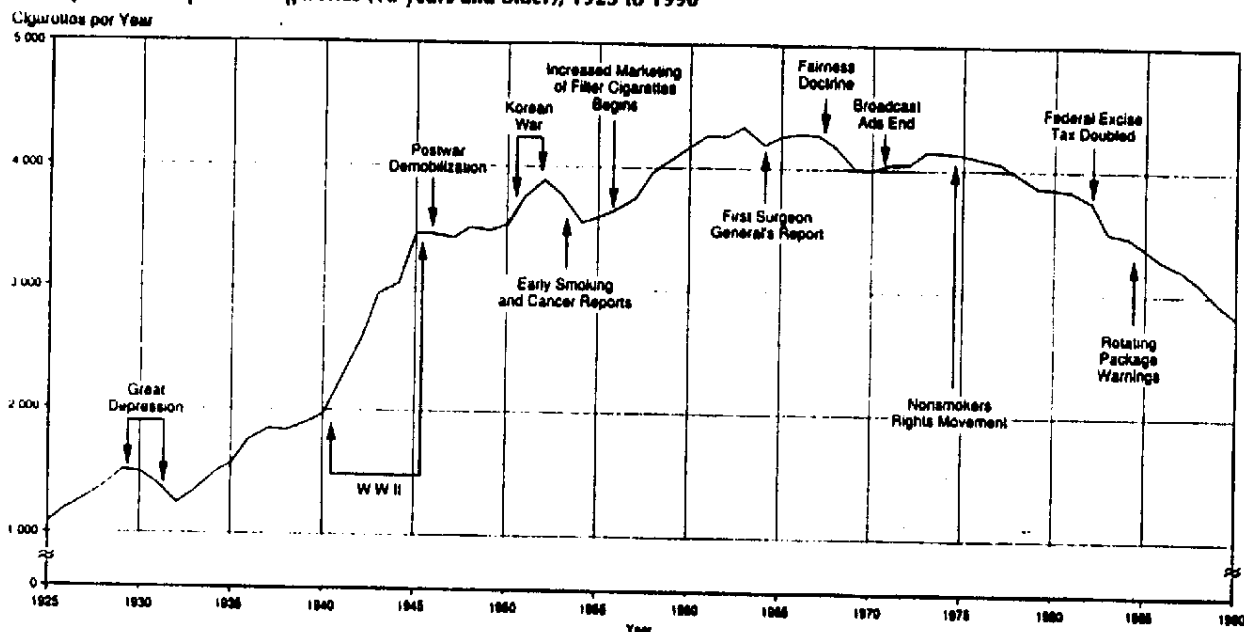
### PUBLIC OPINION AND TOBACCO USE

The addictive nature of tobacco notwithstanding, tobacco use appears to be largely a socially mediated practice that is susceptible to change in the social environment. Changes in cigarette consumption in the United States seem to mirror shifts in public attitudes and opinions about smoking (Warner, 1986a). Figure 1 demonstrates a correspondence between the per capita cigarette consumption of adults and the timing of major public events related to smoking and health. Increasing consumption between 1900 and 1950 can be related to application of newly developed marketing and advertising techniques by the tobacco industry and the impact of World Wars I and II, when millions of men were introduced to cigarettes in the armed forces (Warner, 1986a; Whelan, 1984).

Most studies of seminal events that affected public awareness and knowledge about smoking, such as publication of the first Surgeon General's Report in 1964, have shown significant decreases in cigarette consumption in the year of the event (Hamilton, 1972; Warner, 1977 and 1989). Several studies have found the events to have a cumulative downward influence on demand for cigarettes. Warner, projecting from prevalence rates and trends of the mid-1960's, found that 1985 smoking rates for every age and sex cohort were significantly lower than expected, with the greatest decreases from the projected rates in the younger cohorts (Warner, 1989). He estimated that in 1985 there were 35 million fewer smokers than expected, a 38 percent decline in anticipated prevalence. Warner attributes this difference to changes in the social environment spawned by scientific and social interest in the hazards of smoking (Warner, 1986a and 1989).

As social beings, humans are subject to a desire to conform, to adopt the social conventions, customs, and norms of the majority (Wrightman, 1977). To the extent that individuals perceive their actions as deviant, there will be pressure to conform to the dominant public opinion. The history of tobacco use traced in Figure 1 can be seen in these terms, initially reflecting increasing social sanction of smoking (first by men and then by women), then growing disapproval of smoking as a practice dangerous to the smoker and, later, to others.

Figure 1  
Per capita consumption of cigarettes (18 years and older), 1925 to 1990



## INTERVENTION CHANNELS

### Mass Media

Perception and internalization of social norms arise from a process in which the individual observes the distribution of opinion and behavior in the environment. The environment consists of both primary and secondary social networks (e.g., family, friends, and workplace) and impressions of society at large, derived largely from the mass media (Noelle-Neuman, 1974). In this light, an important function of tobacco advertising and promotion is to fill the environment with messages reinforcing the perception of smoking as a socially approved, accepted, and even desirable behavior (Davis, 1987; Tye et al., 1987; Warner, 1986a).

Efforts to control tobacco use, then, should focus on creating a social environment that provides persistent and inescapable cues to smokers to stop smoking and to nonsmokers not to start. Such an approach assumes that the best way to change individual behavior is to intervene through the social structures in a community that help shape an individual's opinions and attitudes (Warner et al., 1986).

The primary targets for tobacco control interventions are not individuals but the social networks that shape the attitudes of individuals (both smokers and nonsmokers) toward tobacco. For smoking control, the most relevant networks are the media, health care providers, workplaces, and schools. Additional efforts to alter the environment in which the smoker smokes and the adolescent begins to smoke have been made through legislation, restriction on where smoking is allowed, restriction of access to cigarettes by adolescents, and increases in the economic costs of tobacco use. The following paragraphs review the nature of these intervention channels and provide suggestions about how each may be employed in a population-wide smoking control program.

The mass media play a critical role in influencing what society knows, believes, and does with respect to tobacco use (Tye et al., 1987; Warner, 1986a). In 1986, U.S. cigarette manufacturers spent \$3.27 billion on advertising and promotion (Centers for Disease Control, 1990a). Few popular models rival the "Marlboro man" for familiarity; this and other images from cigarette advertisements are seen daily by virtually every American. Moreover, the presence of tobacco advertisements reinforces the perception that "smoking must be acceptable, otherwise the Government would ban it" (Warner, 1986).

Although the tobacco industry has used them to encourage tobacco consumption, the mass media have played and will continue to play an important role in tobacco control efforts (Flay, 1987; US DHHS, 1989a; Warner, 1986a). Media coverage of the tobacco and health issue over the past quarter-century is credited with improving public awareness of



smoking's hazards, shifting attitudes about smoking, and lowering the percentage of smokers in the population (US DHHS, 1989a). However, the public's understanding of tobacco's hazards is still remarkably superficial, particularly among those segments of the population at greatest risk of smoking—the poorly educated, minorities, and teenagers (Warner, 1986a).

In a comprehensive tobacco control effort, the mass media serve a number of important functions, including (1) providing information to the public about facts and issues relating to tobacco use; (2) alerting citizens and policymakers to injurious public policies that promote tobacco use; (3) motivating people to stop or not start using tobacco; (4) recruiting smokers into treatment programs; and (5) conducting smoking cessation programs.

Those who control the media do not necessarily view any of these tasks as their responsibility. To the contrary, a substantial body of evidence indicates that, because they depend on tobacco advertising revenue, the media often evade the topic of tobacco and health (Dagnoli, 1990; Warner, 1985).

#### Tactics

Tobacco control activities directed at the media should seek to accomplish two goals: (1) increase the public's exposure to prohealth, antitobacco messages; and (2) limit the public's exposure to protobacco messages. The following sections briefly discuss tactics for accomplishing these goals.

**Counteradvertising.** Perhaps the most visible use of the mass media for tobacco control has been antitobacco campaigns sponsored by the major voluntary health organizations and Government agencies (Flay, 1987; US DHHS, 1989a; Warner, 1988 and 1989). For the most part, these campaigns have relied on donated air time and advertising space.

One of the most significant periods of antismoking advertising occurred between 1967 and 1970, when the Federal Trade Commission ruled that, under the Fairness Doctrine, television and radio broadcasters were required to donate air time to antismoking messages as a balance to cigarette commercials (O'Keefe, 1971; US DHHS, 1989b; Warner 1977, 1986a, and 1989). At their peak, antismoking messages were given about 1 minute of air time (much of it in prime time) for every 3 minutes of cigarette advertisements (Whiteside, 1971). Several studies support the conclusion that the antismoking messages aired during the Fairness Doctrine era markedly discouraged smoking (O'Keefe, 1971; Warner, 1989). Cigarette consumption declined each year during the campaign (Figure 1) and rose again after removal of cigarette advertising and the antismoking advertisements from the broadcast media in 1970.

This experience supports the idea that a public service announcement campaign can be effective in certain circumstances (Flay, 1987). After reviewing 56 evaluated antitobacco campaigns, Flay concluded that the key element in the success or failure of an antismoking campaign is its intensity. The more intensive the campaign—that is, the greater its reach, frequency, and duration—the greater the impact on behavior. The disappointing results of many health promotion campaigns delivered through the mass media can be traced directly to inadequate exposure of campaign messages (Bettinghaus, 1986; Flay, 1987; McGulre, 1984; Wallack, 1981).

Reliance on public service announcements most often results in campaign messages being seen infrequently (Flay, 1987; Wallack, 1981). In an evaluation of a 6-month antismoking television campaign conducted in media markets in New York and Pennsylvania, Cummings and colleagues reported that half of donated advertisements were aired between 12 midnight and 7 a.m. Airing of the same messages in purchased time significantly improved response, as measured in calls to a hotline (K.M. Cummings et al., 1989).

Several states, including Minnesota, Michigan, and California, have funded antitobacco media campaigns with revenue earmarked from cigarette excise taxes (Johnson, 1990; US DHHS, 1989a). In California, excise taxes are funding a \$28.6 million, 18-month advertisement campaign against smoking (Johnson, 1990). The campaign, launched in April 1990, includes paid advertisements in newspapers and magazines, on billboards, and in prime time on television and radio.

**Public relations events.** Creating events that will be of interest to large segments of the population is an effective and economical way to gain media coverage for tobacco control issues (US DHHS, 1989b). The best known national public relations event for smoking cessation is the American Cancer Society's Great American Smokeout, which has been held annually since 1977 (Flay, 1987; US DHHS, 1989a). The Smokeout is a multimedia event carried out each November throughout the United States. In most communities, it constitutes an 8-day media blitz leading up to Smokeout Day, when smokers are urged to give up cigarettes for at least 24 hours. Public awareness and participation in the Smokeout has been high for years (Flay, 1987; US DHHS, 1989a). A Gallup poll of adult smokers taken after the 1989 Smokeout showed that 85 percent of smokers were aware of the event and 10.5 percent abstained from smoking on Smokeout Day.

In 1987, the American Lung Association began sponsoring Non-Dependence Day, the 5th of July, as a way to bring attention to the problem of nicotine addiction and to offer assistance

to smokers trying to stop. National events such as the Smoke-out and Non-Dependence Day can be used to spin off media events such as television and radio cessation clinics (Flay, 1987), newspaper stories profiling former smokers (Cummings et al., 1987), and communitywide stop-smoking contests (Cummings et al., 1990; King et al., 1987; Pechacek et al., 1985).

Government agencies frequently designate specific times of the year to highlight specific prevention and disease control initiatives (e.g., high blood pressure control week). The State of New York designated the first week of January 1990 as "Tobacco Awareness Week" and granted \$5,000 to county health departments to create local tobacco control events. Those events varied across the state and included poster contests for schoolchildren, stop-smoking contests, smoking policy workshops for businesses, and training programs for health care providers. Local media coverage of events was heightened by the fact that local events were conducted as part of a statewide initiative.

Presentation of research findings is another way to gain access to the media (American Cancer Society, 1987; Davis, 1988a; US DHHS, 1989b). The media's desire for health stories is so strong that even familiar health information can be recycled or repackaged in such a way as to be of interest to media gatekeepers. The best example of such an event is the annual release of the U.S. Surgeon General's Reports on smoking and health. These reports usually contain little new scientific information, but their presentation by the Surgeon General in a high-profile news conference generates extensive media coverage (US DHHS, 1989a). Having a highly visible and credible spokesperson or group deliver the information will often generate media coverage, even when the message is familiar.

Tailoring information for local news media can be an effective way to extend the life of a national news story or create a new media event (American Cancer Society, 1987; US DHHS, 1989b). After a news release on the medical costs associated with treating smoking-related diseases in the United States, several state health departments issued cost information specific to their individual states, which resulted in a new wave of media coverage on the burden of smoking.

**Advocacy.** Media advocacy is the strategic use of the mass media to promote public policy initiatives (US DHHS, 1989b; Wallack, 1990). Media advocacy does not attempt to directly change individual smoking behavior but uses the media to promote public debate about the tobacco issue. It shifts attention from smoking as solely an individual problem to the role of public policy in shaping individual health choices. Media

advocacy stimulates community involvement in defining public policy initiatives that influence the social environment in which consumers make choices about tobacco use.

In contrast to a planned information campaign or public relations effort, a media advocacy campaign is more like a political campaign in which competing forces continually react to unexpected events, breaking news, and opportunities (US DHHS, 1989b; Wallack, 1990). When tons of imported Chilean fruit were banned after the discovery of a small amount of cyanide in two grapes, smoking control advocates alerted the media to the fact that there is more cyanide in one cigarette than was found in the grapes. The Chilean grapes incident was thus used as a vehicle to raise the issue of Government's failure to regulate the tobacco industry.

Specific kinds of knowledge are essential for effective media advocacy: knowing the media, knowing the relevant tobacco policy issues, and knowing how to frame an issue for public debate (US DHHS, 1989b). Tobacco control advocates need to understand how the different media work, that is, what types of stories are deemed newsworthy, how editors decide what stories get covered, and what deadlines and logistical issues might influence coverage. There are several excellent guides available that illustrate media advocacy skills specifically for tobacco control (American Cancer Society, 1987; US DHHS, 1989b).

Providing media advocacy training to interested persons is one way to encourage and enhance the use of news media for control of tobacco use. A communication network among advocates sharing information on local and national activities will promote media advocacy efforts. As noted earlier, local news coverage of smoking control issues is enhanced when local stories spin off from current issues in the national news media (American Cancer Society, 1987; US DHHS, 1989b). Newsletters and computer bulletin board systems provide ways to facilitate timely communications among national, state, and local advocates. The Smoking Control Advocacy Resource Center sponsors an electronic communications network (SCARCNET, 1990).

Because tobacco advertising is nearly ubiquitous, several medical and public health groups have argued that stronger regulatory actions are needed to curb the influence of pro-tobacco messages delivered through the media (American Medical Association Board of Trustees, 1986; Warner, 1986a). Currently, the Federal Government bans tobacco advertising in the broadcast media and regulates the content of tobacco advertisements by Federal Trade Commission action (US DHHS, 1989a).

#### Regulations on Advertising

A number of proposals to further restrict tobacco advertising and promotion are now under consideration by public health groups, state and local governments, and Congress (Colford, 1990; Myers et al., 1989). One such proposal would limit the imagery and graphics of tobacco advertisements to permit only "tombstone ads," with no models, slogans, scenes, or colors. Other proposals that would restrict tobacco advertising and promotion range from a total ban on all tobacco advertising, to limited restrictions, such as disallowing certain types of promotion (e.g., tobacco company sponsorship of sporting and cultural events, brand advertising in movies, and distribution of free samples).

Most of the proposed legislation to regulate tobacco advertising is designated for action at the Federal level because of laws that preempt states and localities from regulating cigarette advertising (Myers et al., 1989; US DHHS, 1989a). However, state and local communities do have jurisdiction in regulating the location of tobacco advertising when the medium is not national in scope. For example, several metropolitan areas (Denver, San Francisco Bay Area, and Amherst, Massachusetts) have prohibited tobacco advertisements on their mass transit systems (US DHHS, 1989a). In Minnesota, the state's Sports Commission banned tobacco advertising in the Hubert H. Humphrey Metrodome (US DHHS, 1989a). The City of Detroit banned tobacco advertisements on billboards (McMahon and Taylor, 1990). The City of New York passed an ordinance prohibiting tobacco advertisements on city-owned property. Numerous cities and two states (Minnesota and Utah) have passed laws prohibiting the distribution of free tobacco product samples (US DHHS, 1989a).

#### Health Care Providers

Tobacco control efforts directed at the health care sector should seek to accomplish the following goals: (1) establish routine counseling on tobacco as a minimum standard of practice for all health care settings (i.e., physicians' offices, hospitals, public health clinics); (2) make all health care facilities smoke-free; (3) increase the number of pharmacies and other health care facilities that will not sell tobacco products; (4) increase the number of health insurance companies that offer financial incentives that discourage tobacco use (e.g., lower premiums for nonsmokers, payment for cessation services); and (5) increase the number of health care providers actively involved in promoting tobacco control initiatives in other sectors of the community, such as in schools, through the media, and in worksites. Intervention activities to achieve these goals fall into three categories: education, economic incentives, and regulation.

#### Education

Antitobacco counseling efforts by health professionals appear to have great potential in encouraging patients to stop or reduce their tobacco use (Glynn et al., 1990). The strength of this approach lies in the large number of smokers who can be reached by credible sources in environments where health is a salient topic. Estimates show that if "stop smoking" messages were routinely delivered to patients by physicians, 38 million smokers could be reached and the number who stop smoking each year could be doubled. Despite the fact that most physicians believe it is their responsibility to encourage their patients to abstain from using tobacco, many fail to do so routinely with all patients (Anda et al., 1987).

A number of barriers to more active involvement in tobacco cessation counseling have been cited. Among them are insufficient time, training, and backup materials to provide effective help (Orlandi, 1987; Orleans et al., 1985). In an effort to address these barriers, several health provider groups have developed training materials and programs to assist health care providers in becoming more proficient in providing tobacco cessation assistance (Davis, 1988b). In 1989, the National Cancer Institute and the American Cancer Society initiated a national program to recruit and train physicians from around the United States who will in turn provide training in tobacco counseling to health providers on a statewide or regional basis. The establishment of a core group of health care providers who are capable of training other providers will in time result in more training opportunities and, presumably, more effective tobacco counseling by all health care providers.

Insufficient time is an important barrier that affects attendance at training programs. Too often those who voluntarily attend training programs are already predisposed and knowledgeable about counseling their patients to abstain from tobacco. To recruit other providers, some groups have advocated visiting health care offices to provide on-site training, much like the pharmacy company sales representatives who make regular visits to health care providers (Kottke et al., 1988). Such an approach has the advantage of involving the provider's office staff in training and provides the opportunity to disseminate relevant tobacco control materials (e.g., self-help guides, labels for patients' charts, list of community cessation services).

Because influential health care providers in a community are often asked to comment on the tobacco issue, providing them with training on effective use of the media is important to ensure that the prohealth message is heard (American Cancer Society, 1987; US DHHS, 1989b). The tobacco control movement has demonstrated that concerned community

leaders, in spite of limited media experience, can be effective media advocates. Experience has also demonstrated that such community-based advocacy can be greatly enhanced if tobacco control advocates are introduced to some basic lessons of media advocacy (US DHHS, 1989b). In the United States, Doctors Ought to Care, a concerned group of physicians and other health professionals, has created satirical media events to publicize the problem of tobacco use and promotion, a prominent example being its sponsorship of the Emphysema Slims tennis tournament as a counterpoint to the Phillip Morris-sponsored Virginia Slims tournament (Doctors Ought to Care, 1989).

#### Economic Incentives

Convincing pharmacists to stop selling a profitable product like cigarettes is not easy (Richards and Blum, 1985). However, the number of tobacco-free pharmacies is increasing, and the American Pharmaceutical Association has endorsed the position that pharmacists should not sell tobacco products (US DHHS, 1989a). In Nevada, a local pharmacist made national news when he built a tobacco "bonfire" to publicize the fact that his store would no longer sell tobacco products. In Erie County, New York, the American Cancer Society urged community pharmacies to stop selling tobacco during the Great American Smokeout. In New Jersey, one advocacy group compiles and publicizes a list of tobacco-free pharmacies (New Jersey Group Against Smoking Pollution, 1988). Pharmacists have been encouraged also to be more involved in counselling their clients on ways to stop using tobacco. In 1982, the National Cancer Institute in collaboration with the American Pharmaceutical Association produced and distributed over 25,000 copies of the "Pharmacist's Helping Smokers Quit Kit" (NCI, 1982).

#### Regulation

Two-thirds of the states now require hospitals to restrict smoking to designated areas (Pertschuk and Shopland, 1989; US DHHS, 1989a). Minnesota was the first state to pass a law that requires all hospitals to be smoke-free.

There are many compelling reasons for health care facilities, especially hospitals, to adopt strong smoking restrictions (Knapp et al., 1986). Permitting smoking in the facility may undermine physicians' advice to stop smoking. Nonsmoking patients in the facility may be adversely affected by exposure to environmental tobacco smoke. The majority of hospital fires are caused by smoking in bed. Finally, other sectors of the community look to actions in the health care sector to model their response to the tobacco issue.

One strategy that has been used effectively to help promote the establishment of stronger smoking policies is to survey patients and staff about their attitudes about restricting

smoking (Kottke et al., 1988). Population surveys have demonstrated strong public support for tough smoking restrictions in health care facilities (US DHHS, 1989a). Getting local medical and public health organizations to endorse smoking restrictions can pressure administrators to institute stronger smoking restrictions (American Cancer Society, 1988; Knapp et al., 1986). Finally, publicly acknowledging health care facilities that have strong antismoking policies may help pressure others to adopt similar restrictions (Kottke et al., 1985). There are several comprehensive guides available that describe strategies for implementing voluntary no-smoking policies (American Hospital Association, 1988; Burtaine and Slade, 1988; Hurt et al., 1989; Knapp et al., 1986).

Licensure requirements for health care facilities could be changed to mandate that tobacco prevention and cessation services be offered. The New York State Health Department is currently considering a regulation that would require hospitals to include plans for cardiovascular disease prevention programs (including prevention of tobacco use) in their application for a "certificate of need" to build a coronary care unit. Similarly, funding for state and local health departments could be made contingent on their providing certain types of tobacco control services.

#### Worksites

Worksites are an important channel for tobacco control because they constitute a setting in which large numbers of smokers can be reached with programs to encourage and support cessation efforts (Fielding, 1984; US DHHS, 1985). Worksites are also an important channel for involving nonsmokers in tobacco control efforts, particularly through the promotion of no-smoking policies (American Cancer Society, 1988).

Tobacco control activities for worksites should seek to accomplish the following goals: (1) increase the number of worksites that provide tobacco control programs for their employees and (2) increase the number of worksites that adopt policies that discourage tobacco use (e.g., no smoking indoors, lower health insurance premiums for nonsmokers, hiring of nonsmokers only). Intervention activities to accomplish these goals fall into the same above-mentioned categories: education, economic incentives, and regulation.

Stimulated by both public and private initiatives, an increasing number of businesses are adopting policies that limit smoking at work. A 1987 national survey conducted by the Bureau of National Affairs found that 54 percent of the businesses responding to the survey had policies limiting smoking at work (Bureau of National Affairs, 1987). The 1986 Adult Use

## Education

of Tobacco Survey showed that 45 percent of employed adults in the survey reported having some smoking restrictions at their workplace (Centers for Disease Control, 1988).

Policies limiting smoking at work have resulted in an increased demand for worksite tobacco education and cessation programs (Martin et al., 1986; Newsweek, 1988). Community organizations such as the American Lung Association, the American Heart Association, and the American Cancer Society have all developed educational programs and materials to assist worksites in providing tobacco education for their employees (LaRosa and Haines, 1986). A number of commercial stop-smoking programs have created programs and marketing strategies specifically for worksites (Newsweek, 1988; US DHHS, 1989a).

In addition to offering educational programs, some businesses offer their smoking employees incentives to stop smoking (Schwartz, 1987; US DHHS, 1985). A common type of incentive is the offer to pay part or all of the cost to attend a cessation program. General Motors absorbs 75 percent of the fee for a smoking cessation program offered to its employees (Schwartz, 1987). Some employers have offered a cash bonus to employees who abstain from smoking (Rosen and Lichtenstein, 1977). Recently, a company in Houston began charging smokers an extra \$10 a month to pay for higher health care benefit costs associated with smoking (Winslow, 1990).

A strong policy against smoking is the cornerstone of a successful workplace tobacco control effort (Emont and Cummings, in press; Fielding, 1986). The most common barrier to adopting a restrictive smoking policy is a perceived absence of employee demand (Bureau of National Affairs, 1987; Emont and Cummings, 1989). In a 1987 survey, two-thirds of companies without policies cited insufficient employee demand as the reason for not adopting a policy (Bureau of National Affairs, 1987). In addition, many employers fear a negative reaction from smoking employees, including possible legal action and grievances (Bureau of National Affairs, 1987). However, surveys of smokers and nonsmokers consistently show support for smoking restrictions at work (US DHHS, 1986 and 1989a).

Conducting workshops to educate employers about the rationale and tactics for implementing smoking restrictions is one approach to encouraging worksites to implement no-smoking policies. Publicizing surveys that demonstrate support for worksite smoking restrictions can be an effective way to make employers aware of employee demand for such policies. In the same vein, actively marketing tobacco control services to worksites, rather than just reacting to requests for such assistance, can substantially increase the number of worksites

## Economic Incentives

voluntarily implementing tobacco control policies and programs for their employees.

A growing body of evidence shows that health care costs are greater for smokers than for nonsmokers (Kristein, 1983; Winslow, 1990). This information is particularly relevant to employers, because a large share of health insurance is purchased by employers as a benefit for employees. The issues related to insurance as an economic incentive are covered later in this chapter.

The courts have established that it is the employer's common law duty to provide a safe workplace. In several cases employers have been held legally and financially responsible for smoking-related illnesses and disability caused by exposure to environmental tobacco smoke at work (Myers and Arnold, 1987). As evidence about the health hazards posed by environmental tobacco smoke continues to mount, the concern about liability for allowing unrestricted smoking at work will probably stimulate more employers to institute restrictive smoking policies (US DHHS, 1986).

## Regulation

Government efforts to regulate smoking restrictions for private and public worksites have increased markedly in the past decade (Pertschuk and Shopland, 1989; US DHHS, 1986 and 1989a). As of 1990, 14 states and nearly 300 cities and counties had mandated the adoption of workplace smoking policies (Pertschuk and Shopland, 1989). There has been little evaluation of the adequacy of implementation or level of compliance with smoking laws. The available evidence does not support the tobacco industry claim that smoking laws in workplaces are expensive and unenforceable (US DHHS, 1989a).

## Schools

Most smokers begin using tobacco before the age of 18; only a small percentage take up smoking after age 21 (US DHHS, 1989a). Most health professionals agree that the reduction of tobacco-caused disease can best be achieved through preventing children from initiating tobacco use (American Academy of Pediatrics, 1987; American Medical Association, 1987; Blum, 1986; Colorado Department of Health, 1986; Coye, 1988; Maine Department of Human Services, 1983; Minnesota Department of Health, 1984; Pennsylvania Plan for Tobacco or Health, 1986; Warner et al., 1986). Schools are important for tobacco control efforts also because they are significant community institutions.

School activities to control tobacco use should seek to accomplish the following two goals: (1) increase the number of schools that implement state-of-the-art tobacco prevention curricula and (2) increase the number of schools that are tobacco-free. Intervention activities to accomplish these goals

Information  
Dissemination

fall into two broad categories: information dissemination, which includes activities to encourage voluntary actions by schools, and regulation, which mandates that schools take specific actions. Examples of each of these intervention strategies are given below.

Since the mid-1960's, tobacco education has been a common element of school health programs. However, the nature of tobacco education efforts and their designated targets have changed over time (US DHHS, 1989a). There has been a shift away from information-oriented programs to psychosocial curricula designed not only to address youth's motivations to smoke but also to impart skills for resisting influences to smoke (Flay, 1985; US DHHS, 1989a). There has also been a shift in the target group from high school and college students to middle school and elementary schoolchildren (US DHHS, 1989a). Although evaluations of school-based tobacco prevention programs indicate that no single program can be relied on to deter adolescents' tobacco use across the board, evidence does point to certain key features of school-based programs that have been consistently associated with positive preventive effects. These include multiple sessions over many grades; information about the social consequences and short-term physiological effects of tobacco use; information about social influences on tobacco use, especially peer, parent, and media influences; and training in refusal skills (Glynn, 1989).

The extent to which state-of-the-art curricula for prevention of tobacco use have been adopted and are used by schools has not been systematically documented, although anecdotal evidence suggests that few school systems provide truly substantial curricula (Best et al., 1988; Cleary et al., 1988; US DHHS, 1989a). Barriers to widespread adoption of tobacco prevention programs within schools include demands on teacher time, cost of materials for specific programs and teacher training, and competing educational and health priorities (Best et al., 1988; Cleary et al., 1988). Packaging program materials so that they are easy for teachers to use will facilitate their adoption. Recruiting and training influential representatives from school systems to serve as local smoking control resources will help ensure that teachers stay current with program materials and will develop advocates for tobacco prevention within school systems (Glynn, 1989).

School-based no-smoking policies are important because the school environment should be free of tobacco smoke, and teachers and school staff are influential role models for children. Evidence suggests that the rules about smoking at school influence the efficacy of tobacco prevention programs. Tobacco education programs implemented in schools that

## Regulation

prohibit smoking appear to be more effective than identical programs in schools with less restrictive policies (Best et al., 1988).

Conducting workshops to educate school administrators and board members about the rationale and tactics for implementing no-smoking policies is one approach to encourage schools to implement such policies. Conducting and publicizing surveys that demonstrate support for tobacco-free schools can be used to pressure school boards to consider implementing stronger tobacco use policies (National School Boards Association, 1987).

School education about the health consequences of tobacco use is mandated by law in 20 states (US DHHS, 1989a). Several states also require teacher training about the effects of tobacco use. In Connecticut, to be certified to teach in public school, a person must pass an exam on the effects of nicotine and tobacco use (US DHHS, 1989a).

Little is known about the level of compliance with state regulations. As noted previously, the nature and scope of tobacco education efforts appear to vary widely across school districts. Regulatory actions that fail to stipulate the nature and scope of tobacco curricula will likely be ineffective. Moreover, standards should be established to guide implementation and evaluation of curricula. Standards should address the curricula that should be used, teacher training, and minimum number of hours devoted to tobacco education at each grade level.

By 1990, 15 states had prohibited smoking by secondary school students, and another 17 states had laws that restrict students' smoking to designated areas (US DHHS, 1989a). Most secondary schools have written policies that prohibit or restrict smoking by students (National School Boards Association, 1987; US DHHS, 1989a). Smoking by school faculty and staff members is generally permitted, but only in areas away from students. Three states, New Jersey, Wisconsin, and Utah, have passed laws that prohibit smoking by anyone on school property. Although most schools have policies regulating smoking, fewer than 5 percent are totally smoke-free (National School Boards Association, 1987). An important barrier to adoption of a tobacco-free policy is concern about opposition from the teacher's union. Union contracts often negotiate smoking areas for teachers, even though the vast majority of teachers do not smoke. Thus, legislation that mandates schools to be tobacco-free is probably necessary. In general, public support is greater for laws restricting smoking in schools than for other locations such as private worksites and restaurants (US DHHS, 1989a). If additional evidence can be produced to demonstrate

a link between school smoking policies and smoking initiation, it is probable that measures to prohibit tobacco use on school grounds will become more common.

Table 1 summarizes the tobacco control activities discussed in this section and identifies groups and organizations that may assume responsibility for each. These interventions may have a greater synergistic effect when combined, compared to the sum of individual effects. The key to a community-based approach lies in assuring that the intervention is broad-based and permeates the social networks.

Although national and statewide initiatives are critical components of a comprehensive smoking control plan, many of the most effective interventions will be individually applied in thousands of cities and towns across the United States. To achieve behavior change in a community, the target population must be involved in identifying the problem, planning and undertaking steps to correct the problem, and creating structures in the community that assure the change is maintained. An underlying assumption is that the community must be empowered to control the intervention and must accept "ownership" of it. This approach has been tested in several community health promotion initiatives, including the Stanford Five-City Project (Farquhar, 1978; Farquhar et al., 1985), the Minnesota Heart Health Program (Blackburn and Pechacek, 1984), and COMMIT—the Community Intervention Trial for Smoking Cessation (Pechacek, 1987). There are two practical ways to implement tobacco control interventions that provide community ownership. These may be described as "social action" and "locality development" (Rothman, 1979).

Social action implies grassroots organizing of disadvantaged and disaffected groups who demand change in the social structure. An excellent example of social action in the tobacco control field is in the formation of local groups (e.g., Group Against Smoking Pollution) to lobby for restrictions on public smoking. Such groups often can be strong advocates for rapid change. The strength of the social action approach is also its weakness: because they are confrontational, grassroots groups provoke conflict and may sometimes inhibit the adoption of consensus.

Locality development maximizes local participation in the intervention by including more than only the most committed groups in the change process. Essentially everyone is invited to join in identifying and solving the problem. An important advantage of this approach is that it expedites participation by established community organizations and increases participation by community leaders.

Table 1  
Examples of tobacco control activities, by channel and group responsible for performance

Channel	Tobacco Control Activities	Groups Responsible*
Media	Sponsor antitobacco informational campaigns	A, B, C, D
	Sponsor smokeout days and/or communitywide cessation events (e.g., TV clinics, contests)	A, B, D, G
	Advertise cessation services	A, B, C, D
	Hold press conferences to release relevant tobacco research findings to the media	A, B; C, D, E, H
	Create events to dramatize the problem of tobacco use in the community (e.g., satirize tobacco promotions)	B, C, G, H
	Conduct and publicize surveys to document support for tobacco control policies	A, B, C, D, E, G, H
	Conduct advocacy training for community leaders	B, H
	Establish a communications network among tobacco control advocates	A, B, H
	Lobby politicians to earmark government funds for counter-advertising and to regulate tobacco ads and promotions	All groups
Health Care Sector	Disseminate materials to assist health care providers in counseling patients who smoke	A, B, C, D
	Sponsor seminars to train health care providers on ways to counsel patients to stop smoking	A, B, C, D, E
	Recruit and train influential health care providers in media advocacy	B, C, H
	Sponsor a program to encourage community pharmacies to become tobacco-free	B, C, E, H
	Conduct surveys of patients, staff, and visitors to document support for tobacco-free health care facilities	A, B, C, D, E, H
	Sponsor seminars to promote tobacco-free health care facilities	B, C, D, E
	Include tobacco education in medical/health professional school curricula	C, E
	Reimburse providers for treating tobacco addiction	I
	Gather data to support health insurance premium discounts for nonsmokers	A, C, E, I
	Lobby politicians to mandate smoke-free health care facilities; mandate insurance coverage for cessation services, and premium discounts for nonsmokers; and mandate performance of tobacco control services by health departments, hospitals, and other health care facilities	All groups

Table 1 (continued)

Channel	Tobacco Control Activities	Groups Responsible*
Worksite	• Disseminate information to support establishment of smoke-free workplace	A, B, C, H, I, J
	• Sponsor seminars to promote no-smoking policies in the workplace	A, B, C, H, I, J
	• Conduct surveys of employees to document support for no-smoking policies and cessation services	A, B, E, H, I, J
	• Gather data to support health insurance coverage of tobacco cessation services	A, E, I, J
	• Gather data to support health insurance premium discounts for nonsmokers	A, E, I, J
	• Lobby politicians to mandate smoking restrictions in workplaces	All groups
	• Lobby politicians to mandate insurance coverage for cessation services and premium discounts for nonsmokers and to provide tax incentives to workplaces that offer cessation assistance to their employees	All groups
	• Support employee litigation against employers who fail to implement meaningful smoking policies	B, C, H, I
Schools	• Disseminate state-of-the-art curricula to schools	A, B, E
	• Sponsor workshops to train teachers to implement tobacco education curricula	A, B, E, F
	• Make presentations on tobacco-free schools to school boards, PTAs	B, C, H
	• Conduct student surveys to document the need for tobacco education	A, B, F
	• Conduct surveys of students, faculty, and school staff to document support for tobacco-free schools	A, B, F
	• Mandate that all teachers receive tobacco education training	A, B, E
	• Lobby politicians to mandate tobacco-free schools	All groups

## \* Key

- A Government health agencies
- B Health volunteers
- C Health professional associations (e.g., medical societies)
- D Hospitals and other health care facilities
- E Universities, including medical schools
- F Elementary/secondary schools
- G Community organizations (e.g., youth groups, service clubs)
- H Activist groups (e.g., Group Against Smoking Pollution, Doctors Ought to Care)
- I Insurance industry
- J Business organizations (e.g., Chamber of Commerce)

Coalition building is a form of locality development. Coalitions encourage local organizations and groups to adopt tobacco control as their own project. Networking among coalition members fosters sharing of resources and reduces conflict. It lends instant credibility to the program because it involves recognized community leaders and tends to isolate opponents.

Involving organizations encourages them to divert their resources to tobacco control, in itself a change in norms. Because community organizations network with each other, this change diffuses throughout the community and affects the membership of every organization. Seen from a systems perspective, change in organizations leads to change in the entire community.

The role of the tobacco control interventionist in a locality development approach is to catalyze and coordinate action by the wide cross-section of organizations and individuals recruited to the effort. Under a broad, communitywide strategy, small task-oriented groups within the coalition pursue specific, manageable goals. Maintaining communication among organizations and promptly resolving disputes is an important function of leadership, and a democratic structure of coalition governance is critical to building a true sense of ownership by all the members.

There are four major steps in the coalition-building process: community analysis, planning, implementation, and maintenance. Each is critical to the development of a lasting tobacco control intervention that will permanently change community structures and norms.

Community analysis provides an accurate, in-depth understanding of the community's needs, resources, social structures, and values. At the same time, it provides an opportunity to begin involving the community in the problem-solving process.

The first task is to define the community geographically. A community may be as small as a neighborhood or as large as a major metropolitan area. The important factors in defining a community are interdependence among important social groups and a sense of shared values and norms that lead to individual identification with the community. Because of the importance of major media in determining such identity and in changing norms, consideration should be given to defining the scope of the community as widely as the area of dominant influence of the local broadcast and daily print media. In any case, such a definition should be undertaken in consultation with the leadership of important community sectors, including health, education, business, labor, and government.

## Community Analysis



Once the community is defined, the next step is to identify the community resources and structures that are potentially available to focus on the tobacco control effort. A large body of quantitative and interpretive data is collected from both secondary sources (e.g., census data, economic reports, histories) and primary sources (leaders and members of the various community sectors). Information should be gathered on the demographic makeup of the population, smoking patterns, and the levels of illness and disability in the community. It should assess the economic structure and well-being of the community, identify business leaders, and tabulate major employers. Political activity and the level of citizen participation should be appraised.

The analysts should carefully assess the level of health promotion and treatment programs available. What resources and skills already exist, and what is the level of service being provided? How ready are providers to join in a tobacco control effort?

The important public and private educational systems should be identified, and the content of the health curriculum appraised. In addition, an effort should be made to identify important social, fraternal, and community improvement organizations and to characterize their memberships. Important religious denominations and major and minor media outlets also must be identified and analyzed. A calendar of major community events should be compiled.

The community leadership structure, because it is likely to affect the intervention, is as important as a list of community resources. What organizations and groups are currently involved in tobacco control? Who are the groups and individuals likely to help or hinder the project? Who are the important leaders who could make a significant contribution? What are competing community priorities, and who are their advocates? How do people want to participate?

This information should be gathered in interviews with community leaders, beginning with those most likely to be interested in the intervention, such as the leadership of major volunteer health organizations and those in charge of health promotion at the local health department and hospitals. From these interviews, influential community leaders will be identified. These leaders in turn should be interviewed to identify additional community leaders and important organizations. This process should be pursued as long as profitable.

The point of the analytic exercise is to determine how the community makes decisions and to begin involving the community in the task of solving the tobacco problem. At the end of the process, the analysts should be able to determine the

community's readiness for change. Are the various elements of the community able to work together to identify and solve common problems? Can they achieve consensus on goals and priorities? Who are the key players who must be part of that consensus? Is there a history of collaboration to build on or must trust-building and conflict resolution be an early component of the tobacco control intervention? To what extent is tobacco control a community priority?

### Planning

At this point the process of planning the intervention begins. A small group of influential individuals willing to commit the time and energy needed to plan and begin implementing the project should be selected. An important consideration in choosing members for this initial group is that major stakeholders be included, that is, those with a preexisting commitment to tobacco control. In many communities this will include representatives of the major voluntary health agencies and other health promotion organizations. Other important community sectors, such as education and business, should be represented if possible.

This planning group will determine the structure and initial membership of the coalition and will begin recruiting members. It will set overall goals for the program and will determine staffing structure, office location, and similar needs. If resources are available to pay a staff, the program director should be hired at this point, and the planning group should have a significant role in writing the job description and screening candidates. Staff support is vital to the success of the intervention. If funds are not available to pay for a staff, individuals employed by health agencies may be reassigned from current activities. In either case, clear role definitions are important.

### Implementation

The program director should be someone familiar with the target community (preferably a member of it) and should be acquainted with local resources, values, and decision-making processes. The most important skill is the ability to "network," preferably on a communitywide level.

The coalition should be as broad as possible and divided into task forces according to members' interests. Obvious choices for task forces would be media, public policy, health care, worksites, youth and education, and cessation services, though there may be others. A scheme for coalition governance should be devised early. Some type of board or executive group is needed to make important management decisions, but care should be taken to ensure that interventions are planned and implemented by the task forces. An important board function may be allocating resources among the task forces, so it is important that the board be responsive to the coalition's membership, possibly through election to fixed terms.

Training and education of board and task force members are important and continuing aspects of the community mobilization process. Most members will not be experts in tobacco control and may approach the problem with strategies that are ineffective or incomplete. They will benefit from further education on the smoking problem, nationally and as it exists in their community, and they should be exposed to strategies established as effective in previous interventions. Many will bring important skills to the program that can be enhanced by training in other areas, but some will benefit from learning new skills. For example, physicians trained in media advocacy can be a powerful addition to the project's efforts.

A strategic tobacco control plan presents the coalition's overall goals and a series of specific objectives toward meeting those goals. It is important both in guiding rational, sequential implementation of the intervention and as a tool for mobilizing the community to recognize tobacco use as an important public health problem. The plan should be a product of the task forces, which will set priorities, identify resources, and plan activities. In developing the plan, the community begins to assume ownership of the project.

Above all, the tobacco control plan should represent a comprehensive, communitywide approach employing multiple, integrated interventions. Coordination among task forces and intervention activities is vital and is the primary responsibility of the program staff. Rather than providing interventions themselves, the staff will identify others in the community to undertake the intervention activities and to coordinate those efforts. A number of state and local tobacco control plans have been produced and are available for guidance (Colorado Department of Health 1986; Coye, 1988; Minnesota Department of Health, 1984).

#### Maintenance

Maintenance of the intervention is necessary to its success. Smoking will not disappear from a community in months or in a few years, and changes in community norms will probably occur over the course of a generation. Any outside financial support for a community intervention will be restricted in amount and duration. More fundamentally, ownership of the intervention will not be complete until the community redirects its resources to smoking control. This action will, in itself, constitute a significant normative change.

Planning for transfer to the community should be an integral part of the intervention. Activities should be structured to elicit the greatest possible participation from community organizations and structures. The strategic use of seed money grants and contracts can build a constituency for tobacco control within organizations and ensure a continuing interest in addressing the problem.

In addition to broadening the group of stakeholders who believe in the importance of tobacco control and have actively worked at it, this approach gives individuals and organizations the experience of successfully implementing programs they might otherwise not have attempted. Selecting low-cost activities, or at least demonstrably cost-effective activities, will increase the sense of self-sufficiency.

Only by letting the members of the community implement the tobacco control program can it continue after outside funding is exhausted. Staff members must not become service providers. Rather, they are facilitators, coordinators, and trainers. It is recognized that the community will make mistakes, but it will learn from these mistakes and, given time, will institutionalize an effective tobacco control program.

#### RESTRICTIVE LEGISLATION

Restrictions on smoking for fire and safety reasons have existed for much of this century, but restrictions based on health and annoyance have been implemented largely over the last two decades (US DHHS, 1986). The major motivations for this new wave of restrictions have been the irritation and annoyance of the nonsmoker caused by environmental tobacco smoke and the evolving understanding of the disease risks associated with exposure to environmental tobacco smoke. Now these motivations are blending to produce a social climate in which cigarette smoking is increasingly unacceptable.

Much of the credit for changes in the social acceptability of smoking has focused on recent events such as the call for a smoke-free society by the year 2000 as well as reports on the scientific evidence by the Surgeon General (US DHHS, 1986), the National Academy of Sciences (1986), and most recently the U.S. Environmental Protection Agency (in press). However, this kind of social shift occurs slowly, gathering momentum with time. The understanding of the risks associated with environmental tobacco smoke began in 1970 when the Surgeon General at that time, Jesse L. Steinfeld, M.D., recognized the clear biological plausibility of a significant public health risk from environmental tobacco smoke. Addressing the National Interagency Council on Smoking and Health, he stated, "Evidence is accumulating that the nonsmoker may have untoward effects from the pollution his smoking neighbor forces upon him." Dr. Steinfeld called for a bill of rights for the nonsmoker (Steinfeld, 1972), and he directed the National Clearinghouse for Smoking and Health to conduct a complete assessment of scientific evidence on the topic for inclusion in the next Surgeon General's Report (US DHEW, 1972).

Those documented concerns, coupled with nonsmokers' annoyance at being exposed to tobacco smoke, ignited the nonsmokers' rights movement. By the mid-1970's, the change in social acceptability of smoking was well under way and has been credited with the downturn in per capita cigarette consumption that began in 1974 (Warner, 1981).

### Federal Actions

Federal Government efforts to restrict smoking have not been as extensive as those of state and local governments. Outside the tobacco belt, state and local governments are less subject to lobbying efforts by the tobacco industry and therefore have passed more laws restricting smoking.

The only area in which Congress has acted to restrict smoking has been aboard commercial airline flights. Until recently, most of the regulation of smoking on airlines was the responsibility of the Civil Aeronautics Board (CAB). In 1971, the CAB mandated that all commercial airline flights provide nonsmoking sections large enough to accommodate every passenger who desired to sit in them, and in 1983 it issued new regulations that banned smoking on flights of 2 hours or less. However, within hours of its announcement, the ban was reversed in the insistence of lobbyists and powerful members of Congress (Walsh and Gordon, 1986).

Nevertheless, public pressure for a smoking ban continued to mount, and as a result, Congress passed legislation in 1987 doing exactly what the CAB had tried to do in 1983—ban smoking on all commercial airline flights of 2 hours or less. This included about 80 percent of all flights within the continental United States (US DHHS, 1989a). In spite of concerns to the contrary, the airlines have found the law to be an easy one to enforce. Flight crews found it necessary to initiate enforcement actions against only 1 out of approximately every 4 million airline passengers in 1988 (Hensley, 1989).

In 1989, Congress again considered the issue of smoking on commercial air flights because the law dictating the 2-hour smoking ban was about to expire. The Senate wanted a total ban on all flights, whereas the House voted only to continue the 2-hour ban. A compromise was reached, whereby the ban on smoking was increased to 6 hours, effectively eliminating smoking on all flights except those to Alaska, Hawaii, and foreign locales, as well as on charter flights (Phillips, 1990).

Most other Federal action regulating smoking has been by agencies restricting smoking at Government worksites. The General Services Administration, which is responsible for one-third of all Federal buildings, prohibits smoking except in designated areas. The Department of Health and Human Services completely bans all smoking in its buildings. In 1986,

the Department of Defense established a new policy to curtail smoking among Armed Forces personnel. As part of the policy, smoking is permitted only in designated areas (US DHHS, 1989a).

### State Legislation

In 1973, Arizona became the first state to restrict smoking in a number of public places because environmental tobacco smoke is a public health hazard. This was done in response to the 1972 Surgeon General's Report, which for the first time identified involuntary smoking as a health risk. The passage of the Arizona law marked a shift in the content of laws regulating smoking. Instead of restricting smoking because it is a fire hazard, likely to contaminate food, or morally wrong, legislatures started restricting smoking because it endangers the health of nonsmokers (US DHHS, 1989a).

Throughout the 1970's, the regulation of smoking in public places became a major issue for state legislatures. In 1974, Connecticut became the first state to pass a law restricting smoking in restaurants, and in 1975, Minnesota passed its Clean Indoor Air Act. This was the first law to use the approach that smoking would be prohibited everywhere except where specifically permitted, thereby making nonsmoking the norm. It was also the first law to extend smoking restrictions to worksites, both public and private. Continuing until today, this law has served as a model for other state legislatures seeking to pass comprehensive smoking legislation (US DHHS, 1989a; Kahn, 1983).

The growth of state smoking legislation was rapid throughout the 1970's and 1980's. Two years that particularly stand out are 1975, in which 13 states enacted smoking laws, and 1987, in which a record 20 states passed such laws. The flurry of activity in 1987 reflected the 1986 publication of reports from the Surgeon General and the National Academy of Sciences, both of which documented the health risks of involuntary smoking (Rigotti, 1989; US DHHS, 1989a). As of August 1, 1990, 45 states and the District of Columbia had passed laws restricting smoking in public places in some manner (Tobacco-Free America, 1990).

The laws that were passed were also more restrictive. Previously, laws restricted smoking only in public places such as elevators or buses, but the new laws began increasingly to regulate smoking in restaurants and private worksites (Rigotti, 1989; US DHHS, 1989a; Warner, 1981). As of August 1, 1990, 27 states regulated smoking in restaurants and 18 states restricted smoking at private worksites (Tobacco-Free America, 1990).

The restrictiveness of state smoking laws varies in different regions of the country. In particular, southern states have fewer smoking laws, and they are less comprehensive. Of the five states that have no laws whatsoever to restrict smoking in public places, two—Tennessee and North Carolina—are major tobacco producers (Rigotti, 1989; Tobacco-Free America, 1990; US DHHS, 1989a).

No-smoking laws passed by the states are generally implemented by the state health departments with minimal burden (US DHHS, 1989a). For example, for the 3 years after the passage of the Minnesota Clean Indoor Air Act, the cost to the Minnesota Department of Health was only about \$4,600 per year (Kahn, 1983).

#### Local Legislation

During the 1980's, efforts to control cigarette use spread to the local level—towns, cities, and counties (US DHHS, 1989a). During the period between 1986 and 1990, a more than fourfold increase occurred in the number of communities with smoking ordinances, from 89 in 1986 (US DHHS, 1989a) to 468 in 1990 (Tobacco-Free America, 1990).

Although state smoking laws are generally called clean indoor air acts, smoking laws at the local level are usually referred to as smoking ordinances (Pertschuk and Shopland, 1989). With few exceptions, these local ordinances are stronger and more comprehensive than corresponding state laws and are often enacted because of difficulties in passing stronger state laws (Rigotti, 1989). A legislative response by the tobacco industry has been to promote state legislation that preempts the right of local communities to pass laws restricting tobacco use. As a result, seven states have passed laws preventing the passage of more stringent ordinances at the local level. In Florida, the law not only prevents the passage of future local smoking ordinances but also preempts all existing ones (Tobacco-Free America, 1990).

The most complete records on local smoking ordinances have been kept for California, which has been a leader in the passage of these laws. The first were passed in 1979, and in 1982, San Diego became the first large California city to enact an ordinance regulating smoking in the workplace (US DHHS, 1989a). In 1983, the San Francisco Board of Supervisors passed an ordinance regulating smoking in private worksites, which later was brought before the voters in the form of a proposition. In spite of heavy opposition from tobacco interests, it passed, and the publicity generated by the campaign stimulated other communities around the country to pass similar ordinances (Martin and Silverman, 1986).

Laws restricting smoking are often called "self-enforcing" because few complaints of violations are filed, and so it is

assumed that most people are obeying the law (Rigotti, 1989). In San Francisco, only 1 out of approximately 60 Department of Public Health inspectors was assigned to enforce that city's Smoking Pollution Control Ordinance. The percentage of time he spent doing that job declined during the first year until, during the last 4 months, only 21 percent of his time was spent on the program. No additional funds were needed to enforce the law (Martin and Silverman, 1986). Similarly, New York's Health Department reported receiving only a few complaints after that the city's no-smoking law restricted smoking in restaurants (US DHHS, 1989a).

An effort to actively measure compliance with laws restricting smoking, rather than just counting the number of complaints received by a health department, was made in Cambridge, Massachusetts. Researchers asked city residents whether they had recently noticed smoking in places where it was not permitted 3 months after the passage of a city smoking ordinance. One-third, it turned out, had noticed illegal smoking. Asked what their response was, most people said that they had ignored the violation (US DHHS, 1989a).

#### Public Opinion

Rigotti (1989) makes the point that public support for smoking restrictions was present long before either the passage of no-smoking laws or the publication of most of the evidence that passive smoke could be damaging to one's health. As early as 1964, most nonsmokers felt that smoking should be allowed in fewer places, and by 1975, a majority of both nonsmokers and smokers felt that way. In 1987, a Gallup poll found, for the first time, that a majority of all adults (55 percent) favored a complete ban on smoking in all public places (US DHHS, 1989a).

#### Effects of Restrictions On Smoking Prevalence

In 1982, the government of Hong Kong began making a concerted effort to reduce smoking in that city. Smoking was restricted in public places, a fourfold increase in the duty paid on tobacco was instituted, public health education was increased, and an antismoking publicity campaign launched. As a result, 16 percent of the population quit smoking between 1982 and 1984, and the number of regular smokers between the ages of 15 and 19 was cut in half. When ex-smokers were asked in surveys which factors were influential in causing them to quit, respondents identified two main ones—cost and health concerns (Mackay and Barnes, 1986).

A similar effort to decrease smoking was instituted by the U.S. Department of Defense starting in 1986. Between 1985 and 1987, smoking prevalence decreased in all branches of the Armed Forces, particularly in the Army, which was the branch most active in getting its personnel to eliminate smoking (Hagey, 1989; Rigotti, 1989; US DHHS, 1989a).

Data collected by the Wisconsin Department of Health and Social Services show the effects of the antismoking campaign in that state. Per capita sales of cigarettes in Wisconsin started dropping off sharply from a peak in 1981. Coincident with this dropoff were two cigarette tax increases, one state and one Federal, and the 1983 passage of Wisconsin's Clean Indoor Air Act (Centers for Disease Control, 1989).

#### Employee Attitudes

Worksite smoking restrictions are gaining acceptance among workers, including smokers (Becker et al., 1989; Blener et al., 1989a; Sorensen and Pechacek, 1989). Sorensen and Pechacek found support for no-smoking policies among smokers who were interested in quitting, those who were concerned about the health effects of smoking, those who indicated a high level of support from coworkers for previous quit attempts, and those who had a high number of nonsmoking coworkers. This may help to allay the fears of employers who believe that smoking restrictions will lead to dissension or low morale among employees. In most situations, smoking restrictions can be implemented without significant conflict.

A study that included a survey of smokers outside office buildings in Pasadena showed similar support from smokers for smoking restrictions. Pasadena citywide smoking regulations require restrictions in all indoor places, including worksites. In the study by Sussman et al. (in press), a majority of smokers interviewed thought it was important to stop smoking and had positive feelings about the nonsmokers' rights movement. In addition, about three-quarters of the smokers had made at least one quit attempt, with those subject to no-smoking policy reportedly putting more effort into quitting smoking. The researchers caution that "little is known about attitude-behavior relationships and smoking policy effects" (Sussman et al., in press).

#### Impact of Worksite Restrictions

Millar (1988), in a government work setting, found a continuous quit rate of 3.5 percent at 1 year after smoking restrictions went into effect. Two hundred registrants for a smoking cessation course were surveyed at 6 weeks, 6 months, and 1 year after smoking restrictions began. The overall smoking prevalence in the year after restrictions declined from 29 to 24 percent.

A recent study analyzed the impact of a strict smoking policy at the Texas Department of Human Services (Gottlieb et al., 1990). The policy limited smoking to break rooms or lounges and cafeteria smoking sections. Regional administrators were given the authority to declare a worksite smoke-free if no appropriate room was available, and smoking was banned outright in 4 of the 12 regions. Again, most of the departments studied had some restrictive policy in effect prior to implementation of the new policy and before the study began.

The Texas study showed that the reduction in smoking prevalence at 6 months after policy implementation was greater in the work areas with smoking bans than in those with smoking restrictions. Consumption of cigarettes at work decreased in work areas with both types of policies. However, the authors concluded that although daily consumption of cigarettes at work decreased significantly, "no significant change was detected in smoking prevalence."

The authors of the Texas study summed up in this way: the "failure to find changes in smoking rates may also have been due to an insufficient follow-up period. Quitting smoking has been conceptualized as a process of change, with smokers moving through the stages of precontemplation, contemplation, action, and maintenance. It is possible that the smokers had increased their readiness to quit but not yet taken action" (Gottlieb et al., 1990).

#### Impact of Smoking Bans

The Australian Public Service used a sample of 2,113 employees who were surveyed 2 to 4 weeks before a complete workplace smoking ban was implemented and again 5 to 6 months later (Borland et al., 1990). Fifty-seven employees who were smoking at the time of the initial survey were not smoking at the time of the followup surveys. However, 36 previous nonsmokers reported starting smoking; it was not noted whether the 36 were relapsing ex-smokers or new smokers. Including the 36 employees who took up smoking brought the reduction findings to a 1 percent reduction in prevalence over the 6-month period, which was not considered significant by the study authors. However, because it is unlikely that these employees took up smoking as a result of the workplace smoking ban, including them in the equation reduced the drop of prevalence that might have been found.

An additional indicator that the reported drop in prevalence might be low is that the work settings in which this study was conducted had various levels of restrictions on smoking prior to the mandated ban. It is therefore possible that some smokers had already quit as a result of a smoking control policy prior to the ban and that this reduction in prevalence was not captured in the study.

The study reached its conclusions on smoking prevalence by conducting pre- and postpolicy surveys on workplace smoking consumption. The smokers were asked to estimate the number of cigarettes they usually smoked on both workdays and nonworkdays and to recall the number of cigarettes they smoked in the previous 24 hours, divided into seven time periods. The study showed that moderate and heavy smokers

had fewer cigarettes during the day, with the greatest change among heavy smokers. Small increases in smoking rates outside the work environment did not compensate for the enforced reduction at work.

In a more recent study at the Johns Hopkins University, however, a significant reduction in smoking prevalence was found to result from implementation of a total ban on smoking (Stillman et al., 1990). As of July 1, 1988, smoking was banned in all areas of the Johns Hopkins Hospital complex involving 24 buildings in an area covering 12 square blocks. The previous policy had allowed smoking in designated areas of cafeterias, waiting areas, and lounges. The new policy was announced on January 1, 1988, and the announcement was followed by an extensive internal media campaign. A health-oriented campaign that emphasized the effects of passive smoking and included free screening for exhaled carbon monoxide was launched. Educational programs to ensure policy enforcement were offered to the staff, and four smoking cessation options were offered free to all employees. In addition to these efforts, discreet observations of visitor and employee smoking were performed monthly beginning 8 months prior to the ban and at 1 month and 6 months after the ban started.

The initial survey of 8,742 full- and part-time employees was distributed 6 months prior to the ban, thereby allowing for inclusion of smokers who ceased in anticipation of the ban. One year after the initial survey and 6 months after the ban, respondents who were still actively employed (4,480) were mailed a followup survey. A significant decrease in employee smoking prevalence was found (21.7 percent before the ban to 16.2 percent after the ban).

There is no consensus whether smoking restrictions encourage smokers to quit or the extent to which restrictions alter behavior. Some researchers have suggested that, over time, smokers may adapt smoking behavior to smoking restrictions, rather than using the restrictions as an incentive to quit (Blener et al., 1989b). Others suggest that worksite no-smoking policies encourage smokers to put more effort into quitting (Sussman et al., in press). Although restricting the areas in which smoking may occur might reduce the cues that encourage smoking, it is also suggested that the smoking area itself could become a cue to smoke (Glasgow, 1989). Additional research may provide more insight about this area.

A number of investigators have made suggestions for the important elements to successfully introduce worksite smoking restrictions and make them as effective as possible. Announcing the restriction or ban well in advance is essential. This will

allow time for smokers to prepare for quitting or to make adjustments. Rosenstock and colleagues (1986) recommended introducing new policies gradually, offering smokers an opportunity to express their dissatisfaction, and making clear the limitations of employee influence over the new policy. Millar (1988) suggested that, in designated smoking areas, smokers be separated from nonsmokers and that smoke be vented to the outside and not through the building's ventilation system. Finally, smokers' efforts to quit should be aided by available cessation classes, coworker support, publicity regarding adverse health effects, and ex-smoker support groups.

In conclusion, there is some evidence that worksites that eliminate smoking completely, offer cessation clinics and other incentives to encourage smoke-free lifestyles, and implement comprehensive health promotion measures will experience a measurable drop in smoking prevalence.

#### PREVENTING TOBACCO SALES TO MINORS

In the United States today, more than 3 million children under the age of 18 regularly smoke cigarettes or use smokeless tobacco. More than 2 million others are actively experimenting with tobacco use and are at high risk for becoming regular users. Tobacco companies collect more than \$1.25 billion annually from the sale of their products to minors (DiFranza, 1989).

More than half of all smokers begin before the age of 14, and 90 percent begin by the age of 19. Tobacco use by young people is a problem easily understandable in terms of economic demand and supply. A major factor in creating demand for tobacco within young age groups is tobacco industry advertising and promotion. Inadequate and unenforced laws assure that this demand is met with a readily available supply. In the 6 years following the introduction of Virginia Slims and other "feminine" cigarettes in 1968, the number of teenage girls who regularly smoke more than doubled. During the late 1970's, the rate of smoking among teenage boys decreased, whereas female smoking remained high.

Although 45 states and the District of Columbia prohibit the sale of tobacco to minors, most often defined as anyone under the age of 18, youngsters who want to obtain cigarettes find it easy to do so. An estimated 1 billion packs of cigarettes are sold to minors under the age of 18 every year, usually in violation of the law (DiFranza and Tye, 1990). The National Adolescent Student Health Survey of 12,000 students found that 86 percent of respondents believed it would be easy for them to obtain cigarettes (American School Health Association, 1989).

#### Effect on Continuing Smokers

#### Elements Needed For Worksite Restrictions

### Minors' Access To Tobacco

There are many reasons to prevent minors from obtaining tobacco products. First, easy availability conveys a message that the substance is not really very harmful. Second, illegal tobacco sales to minors foster disrespect for the law and may help young people toward illegal purchases of alcohol or use of illicit drugs. Third and most obvious, the harder it is for young people to obtain tobacco, the fewer will use the substance.

By 1990, 45 states had some legislation preventing minors' access to tobacco products. Only three, however (Indiana, Utah, and Idaho), are considered to meet the standards for even "basic" coverage, based on criteria established by the U.S. Office on Smoking and Health, meaning that in addition to establishing a minimum age for sale, there are penalties for merchants selling tobacco to minors and some restrictions on the placement of cigarette vending machines. Six states have no minimum age law whatsoever (Montana, Wyoming, New Mexico, Missouri, Louisiana, and Kentucky). No state law is considered to be "comprehensive," which in addition to the basic category's requirements would include a requirement for warning signs at the point of purchase, provision to revoke merchant licenses for violation, and a ban on the distribution of free tobacco products (Centers for Disease Control, 1990b).

A DHHS study of enforcement of laws prohibiting the sale of tobacco to minors was able to document only 32 instances of those laws having been enforced outside of Utah, which has a relatively good record (Office of the Inspector General, 1990). In his 1989 report, the Surgeon General stated:

In marked contrast to the trends in virtually all other areas of smoking control policy, the number of legal restrictions on children's access to tobacco products has decreased over the past quarter-century. Studies indicate that compliance with minimum-age-of-purchase laws is the exception rather than the rule (US DHHS, 1989a).

### Sales by Retail Stores

In studies across the country, it has been shown that, on average, 75 percent of retail stores sell tobacco to minors as young as age 12. In one Massachusetts community, an 11-year-old girl was successful in purchasing cigarettes at 75 out of 100 attempts (DiFranza et al., 1987). In the largest trial of this type, in Santa Clara County, California, 18 minors aged 14 to 16 visited 412 stores and 30 vending machines with the intent of purchasing cigarettes. They were successful at 74 percent of the stores and 100 percent of the vending machines (Altman et al., 1989). In Erie County, New York, minors purchased cigarettes in 77 percent of stores that had received a special mailing about the law prohibiting tobacco sales to minors, and in 88 percent of stores that did not receive the mailing (Skretny et al., 1990).

Table 2  
Survey of Minnesota 10th graders

Location	Percentage of Yes Responses*
Drug Store	42
Grocery Store	53
Convenience Store	68
Vending Machine	71
Gas Station	80

\*Question: Have you purchased tobacco at these places?

Attempts to purchase tobacco products in at least 18 different communities have yielded similar results: On average, three of four retail stores will sell tobacco to minors, in violation of the laws of their state (Tobacco and Youth Reporter, 1989a).

Researchers asked 10th graders in two Minnesota communities "Have you ever purchased cigarettes from any of these places?," with the results shown in Table 2. Most teens thought it would be "very easy" (55 percent) or "fairly easy" (31 percent) to obtain cigarettes. Among teenage smokers, 90 percent thought it was "very easy" to obtain cigarettes (Forster et al., 1989).

### Vending Machine Sales

As mentioned above, when minors aged 14 to 16 attempted to purchase cigarettes from 30 vending machines in Santa Clara County, California, they were successful in all 30 attempts. Even after a massive community education program had reduced illegal over-the-counter cigarette sales to minors by 50 percent, followup tests showed vending machine sales allowed minors to purchase cigarettes 100 percent of the time.

In a major study covering the three-state area surrounding Washington, D.C., Davis and colleagues escorted minors to 120 cigarette vending machines (twice each, for a total of 240 attempts). The children were successful in 100 percent of attempts to buy cigarettes (Davis et al., 1989). Davis concluded that "teenagers have easy access to cigarette vending machines in three different jurisdictions in the Washington, D.C., area. There is every reason to believe that this reflects the situation across the country" (Tobacco and Youth Reporter, 1989b). Identical results were obtained when minors were escorted to cigarette vending machines in New York, Colorado, and New Jersey.

A study by the National Automatic Merchandising Association, the trade association for the cigarette vending machine business, confirms the impression that vending machines are the source of cigarette supply for many very young teenagers when they first begin to experiment with smoking. The study found that, while only 16 percent of teens regularly obtained their cigarettes from vending machines (which still represents more than half a million teenagers), vending machines are a key source of supply for young teens. Among the study's conclusions were:

- Thirteen-year-olds are 11 times as likely as 17-year-olds to buy cigarettes from vending machines (22 percent vs. 2 percent).
- Most teens (56 percent) say they use vending machines "because no one will stop me from buying cigarettes this way."
- Whereas virtually all teenage smokers (96 percent) had been stopped from buying cigarettes over the counter, only about 1 in 10 had ever been stopped from buying cigarettes from a vending machine.
- A growing trend is to sell cigarettes and candy from the same vending machines, which is likely to further encourage and facilitate cigarette sales to minors.

#### Free Cigarette Samples

Tobacco companies spent \$265 million giving away cigarette samples through direct distribution or coupons during 1988, the most recent year for which data are available (Centers for Disease Control, 1990). One of the key functions of tobacco company giveaways is to provide young people with their first experimental packs of cigarettes or smokeless tobacco products at no cost and little risk of being caught. That young people are the target for many free cigarette distribution campaigns was made clear by a recent Camel advertisement that included a coupon with the encouragement to get a friend or a "kind-looking stranger" to redeem the pack for you if you are uncomfortable, an obvious come-on to underage youth.

Sean Marsee, the Oklahoma youth who died at age 18 of mouth cancer caused by using smokeless tobacco, got started when a tobacco company representative gave him a free pack of snuff at a rodeo. Indeed, giving free samples to young nonusers has been a foundation of the growth strategy of the U.S. Tobacco Company (makers of Skoal, Copenhagen, Happy Days, and other smokeless tobacco products). The company has run advertisements in youth-oriented magazines offering free samples, complete with instructions for use, and gives free samples to young people at music, sports, and other events.

Davis and colleagues asked a large number of young people if they had personally been given free tobacco samples;

14 percent of the total and 20 percent of the high school students responded in the affirmative. Approximately half reported having seen other teenagers being given free cigarette samples (Davis and Jason, 1988).

DiFranza organized a group of young people to send coupons in response to tobacco company solicitations for free tobacco samples being sent through the mail. Fifteen of twenty were mailed free tobacco samples at home, in violation of Massachusetts state law (DiFranza, 1989).

#### Action at the Community Level

Over the past several years, there has been a flurry of activity to prevent the sale of tobacco to minors. Much of this action has been at the community level. For example, in Santa Clara County, California, a major communitywide education campaign resulted in a 50 percent reduction in the number of stores selling tobacco to minors (from 74 percent to 38 percent), although there was no impact on the rate of sale by vending machines, which remained at 100 percent (US DHHS, 1989a).

In Woodridge, Illinois, police officer Bruce Talbott successfully pushed for enactment of a local ordinance requiring tobacco merchants to obtain a license and providing for fines and licensure revocation for violation of the law prohibiting sale of tobacco to minors under age 18. Compliance is monitored by means of "sting" operations in which a minor is escorted to stores. If cigarettes are sold to the minor, the store owner must pay a fine. Since enactment and enforcement of the law, the proportion of stores in Woodridge selling tobacco to minors has declined from 92 percent to 0.

In Minnesota, the town of White Bear Lake outlawed cigarette vending machines in 1989. Since that time, 8 other communities have followed suit, 11 have imposed more limited restrictions, and 10 others are considering restrictions. A tobacco company effort to enact state legislation that would preempt these local ordinances failed (Jean Forster, Ph.D., personal correspondence). The State of Utah, using evidence that lockout devices on cigarette vending machines in that state failed to prevent access by minors, outlawed cigarette vending machines from all areas accessible to minors. The law was upheld by the Supreme Judicial Court of Utah against a challenge from the vending machine industry.

A number of jurisdictions have outlawed the distribution of free tobacco samples. They are totally prohibited in Minnesota and Utah; it is illegal to distribute smokeless tobacco samples in Nebraska. Eight communities in Massachusetts prohibit giveaways of tobacco samples.



Another step that is being taken by an increasing number of jurisdictions is to post signs that warn against tobacco sales to minors. This may be effective not only at warning would-be underage tobacco purchasers but also at reminding store personnel of the law.

A growing number of activists, impatient with the sometimes slow progress of enacting controls over the sale of tobacco to minors—often in the face of determined tobacco industry resistance—have taken to direct action against cigarette vending machines. For example, one antismoking organization published instructions for disabling cigarette vending machines, including the use of bent paperclips and coins dipped in Superglue. Another produces "out of order" stickers that can be placed over the coin slot of cigarette vending machines.

Stop Teenage Addiction to Tobacco (STAT) is a nonprofit educational organization that was founded in 1985 to eliminate tobacco addiction of adolescents by raising public awareness of how tobacco companies use sophisticated marketing campaigns to attract young people and how ready access increases tobacco consumption among young people. STAT has prepared model legislation that has served as the basis for legislative efforts in a number of communities around the country. Its "Position Paper on Tobacco-Free Schools" has helped many jurisdictions eliminate school smoking. STAT is forming a national network of community organizers to implement strategies that will reduce the sale of tobacco to minors.

#### A Public Policy Agenda

Eliminating the sale of tobacco to minors is an essential step if we are to achieve the national public health goal of a smoke-free society. Based on research and review of what has been effective at the state and community levels, the following steps are probably necessary.

- All free distribution, "sampling" in tobacco industry parlance, must be outlawed. The offer of free cigarettes and smokeless tobacco products is reminiscent of the drug pusher who gives the first sample free to get his customer hooked.
- Legislation at either the state or local level should establish that any merchant must obtain a license prior to selling tobacco products. There must be a provision that repeated violation of the law prohibiting tobacco sales to minors will result in meaningful monetary fines and/or extended revocation of that license. There should be provision that enforcement will be ensured by means of sting operations conducted by either the police or health department of the jurisdiction (the Tennessee

state law explicitly provides that it is not entrapment for a youth under official supervision to attempt to purchase cigarettes to monitor compliance with the law).

- In light of their potential to start young people on the course of tobacco addiction, cigarette vending machines must be outlawed. The Nation's 374,000 cigarette vending machines are an open invitation to addiction for the Nation's young people. A vast majority are located in areas where they cannot be effectively supervised. With the proliferation of 24-hour convenience stores over the past several decades, cigarette vending machines can no longer be justified.
- Signs should be required providing notice of the minimum-age-of-purchase law and of the store's intent to abide by the law.
- The legal age for sale of tobacco should be raised to 21, making it consistent with the age for legal sale of alcohol. This will send an important message that tobacco is just as hazardous as alcohol. It will also make it simpler for merchants to monitor identification for sale of products that are legal for adults but not for minors by establishing a consistent age for both tobacco and alcohol. Perhaps most important, because relatively few high school students are friendly with 21-year-olds (though many know 18-year-olds), this would reduce access to tobacco products for high school students.
- Smoking by students should be prohibited in schools. In addition, smoking by adults should be prohibited on school campuses, establishing teachers as appropriate role models.
- Tobacco prices should be increased by means of taxation because young people are price sensitive in their demand for tobacco products. Ideally, revenue generated by increased taxes should be used for health education, as has been done with Proposition 99 tax revenues in California.

#### ECONOMIC INCENTIVES

This section describes environmental manipulations based on the application of economic incentives. Economic incentives serve to reduce consumption of tobacco products by increasing, either directly or indirectly, the costs of using these products. In this section, three economic incentive policies are examined: (1) higher excise taxes on cigarettes, (2) preferential hiring and promotion of nonsmokers, and (3) insurance premium differentials for smokers and nonsmokers. An attempt is made here to present some of the conceptual linkages between economic incentives and smoking and to describe the development and current status of each of the three strategies.

# Excise Taxes on Tobacco Products Past and Current Status

The excise tax is an administratively simple mechanism through which public policy can influence the price of tobacco products. The chief purpose of excise taxes has always been generation of revenues, although recently these taxes are receiving increased interest and support as a public health measure.

A Federal excise tax on cigarettes has existed since 1864 and was an especially important source of Federal revenues before the enactment of the Federal income tax in 1913. Since 1951, the tax rate has been raised twice. In 1982, it was doubled from 8 cents to 16 cents per pack; and in 1990, it was raised 8 cents to be implemented in two stages.

In 1921, Iowa became the first state to implement an excise tax on cigarettes. By 1960, all but four states had enacted cigarette excise tax policies, and in 1969 North Carolina was the last state in the Nation to do so. Currently, 396 city and county governments also impose an excise tax on cigarettes. These local governments are largely concentrated in just a few states, and in 1988 they were responsible for 2 percent of all excise taxes collected on cigarettes (Tobacco Institute, 1990).

One of the largest single-year increases ever in a state excise tax on cigarettes occurred recently in California. In January 1989, Proposition 99 raised the tax from 10 to 35 cents per pack, boosting the California tax to one of the highest in the Nation. There is now substantial variability in the excise tax rate among states.

An important historical perspective on cigarette excise taxes is gained by considering the relative contribution of the tax to the overall price of cigarettes. Table 3 shows the percentage of the average price of cigarettes accounted for by Federal and state taxes from 1954 to 1988. This table shows that the Federal tax is declining as a proportion of the total cost of cigarettes. Even with the 8-cent increase in 1983, the relative impact is quickly being eroded by inflation toward the pre-1983 level. The overall relative decline in Federal revenues also holds when compared with either the consumer price index or gross national product. As a percentage of the total Federal tax base, revenues from cigarette excise taxes have declined from 3 percent in 1950 to 0.5 percent in 1987. Since the early 1970's, state revenues as a percentage of the total price of cigarettes have also declined appreciably. Without constant re-adjustment of the rate, real revenues from excise taxes will continue to decline as long as a unit rate is used. Annual adjustments to the Federal tax based on a cost-of-living index have been proposed. Alternatively, an *ad valorem* tax would index the tax rate to the price of cigarettes. As of 1988, Hawaii was the only state to use this method.

Table 3  
Excise taxes as percentage of cigarettes' total cost to consumers

	Federal and State Taxes*	Federal Taxes	State Taxes
Year*			
1955	48.7%	36.7%	12.0%
1956	47.4	34.9	12.5
1957	46.8	35.4	13.4
1958	48.0	36.1	11.9
1959	46.6	32.9	13.7
1960	48.9	32.2	16.7
1961	48.6	31.6	17.0
1962	48.3	30.6	17.7
1963	49.4	31.1	18.3
1964	49.3	30.1	19.2
1965	49.8	29.9	19.9
1966	51.4	28.4	23.0
1967	50.8	27.7	23.1
1968	49.2	25.2	24.0
1969	48.9	24.0	24.9
1970	47.7	21.7	26.0
1971	46.8	20.9	25.9
1972	47.7	20.0	27.7
1973	48.4	19.9	28.5
1974	47.8	19.9	27.7
1975	44.5	17.9	26.6
1976	41.4	16.9	24.5
1977	40.5	15.8	24.7
1978	37.1	14.4	22.7
1979	35.5	13.8	21.7
1980	34.5	14.0	20.5
1981	33.1	12.8	20.3
1982	29.9	11.4	18.5
1983	28.8	12.0	14.8
1984	33.2	17.3	15.9
1985	32.3	16.2	16.1
1986	30.8	15.2	15.6
1987	29.9	15.1	14.8
1988	28.8	13.7	15.1
1989	26.5	12.0	14.5
1990	26.4	11.2	15.2

\*Source: Tobacco Institute (1990).

\*Fiscal year ending June 30.

Anticipated Effects  
Of a Tax Increase

How much reduction in smoking might we expect in response to increasing the price of cigarettes? The quantitative relationship between price and demand is described by economists as price elasticity, which is defined as the change in demand for a product relative to the change in price. For example, a price elasticity of -0.5 implies that a 10 percent increase in the price of a product will result in a 5 percent decrease in the quantity demanded. Note that a given tax increase must first be translated into the percentage increase in the retail price before its effect can be estimated.

Studies on the price elasticity for cigarettes in the United States were summarized in the 1989 Surgeon General's Report (US DHHS, 1989a). Thirteen studies conducted since 1980 were identified. Overall price elasticity estimates varied from -0.14 to -1.23. However, there was a clustering of short-term elasticity estimates in the -0.4 to -0.5 range, and the mean estimate was -0.43. These estimates are similar to those obtained in European studies, as summarized by Pekurinen and Valtonen (1987) and Godfrey and Maynard (1988). Considering the differences in cultural attitudes toward smoking, varying levels of government involvement in antismoking health education, and substantial variations in the real price of cigarettes, the overall level of agreement between the American and European studies adds a degree of confidence to the general findings of these studies.

Overall price elasticities convey no information regarding which groups and types of smokers are more sensitive to price changes. However, by analyzing survey-based data rather than aggregate consumption data, Lewit and colleagues have attempted to answer several critical questions about differential impacts. Using a sample of nearly 20,000 adults surveyed in the 1976 National Health Interview Survey, Lewit and Coate (1982) found that the consumption response to a price increase occurs primarily through reduction of smoking prevalence, rather than reduction of the average number of cigarettes smoked per smoker. The elasticity for participation, that is, the number of smokers, was found to be -0.26. The elasticity for the number of cigarettes per smoker was only -0.10. Thus, it would appear that the primary impact of an increase in the cigarette excise tax would be to encourage some smokers to quit, but the majority of smokers would continue to smoke about the same amount.

Studies that have examined age-specific responses to the price of cigarettes are of particular interest to public health professionals because they assess the potential impact of price policy on teenage smoking. It is well known that most adult smokers started before the age of 20, and thus a high priority for smoking control efforts is the reduction of teenage smoking

Table 4  
Age-specific estimates of the price elasticity of demand for cigarettes

	Elasticities		
	Overall	Participation	Quantity per Smoker
Age Group			
12-17 yr	-1.40	-1.20	-0.25
25	-0.89	-0.74	-0.20
28-35	-0.47	-0.44	-0.04
36-74	-0.45	-0.15	-0.15
All adults	-0.42	-0.26	-0.10
All ages	-0.47	-0.31	-0.11

Adapted from US DHHS (1989a, p. 537), and US GAO (1989, p.30).

rates (DiFranza et al., 1987). The first study (Lewit et al., 1981) found the price elasticity for youths aged 12 to 17 to be -1.40, a substantially higher figure than for adults. Similar to adults, adolescents also respond to price primarily through participation, rather than the quantity smoked per smoker. The price elasticity estimates for participation and quantity smoked were -1.20 and -0.25, respectively. A second study, by Grossman and colleagues (1983), used data from four smaller, more recent samples provided by the National Surveys on Drug Abuse. The estimated price elasticities for participation were all less than the figure obtained in the earlier study. To obtain their summary estimate of -0.76 for these studies, the authors excluded the highest and lowest figures and averaged the remaining two. The authors of a General Accounting Office report on teenage smoking suggest relying on this lower elasticity estimate, rather than the -1.20 figure, because of the recency of the data used in the second study (US GAO, 1989). A summary of the elasticity estimates provided by these studies is shown in Table 4.

The participation elasticity estimates provided in Table 4 may be used to project the decrease in smoking prevalence related to a given tax rate change. The current price of cigarettes is needed to convert the tax increase into the percentage change in the retail price of cigarettes. Also necessary are estimates of current prevalence of smoking. For example, Warner (1986b) projected the reduction in prevalence in adult cigarette smoking for three specific values of possible tax rate changes. In 1986, a 16-cent-per-pack increase in the excise tax would have raised prices 15.1 percent. Based on 1982 prevalence data, this would be expected to reduce the number of adult smokers by over 2.5 million (3.9 percent). More recently,

Cummings and Sciandra (1989) have used similar methods to estimate the response in overall smoking prevalence in New York State to a scheduled 12-cent increase in the state excise tax.

The US GAO report (1989) employed analogous procedures to estimate the effect of a tax increase on teenage smoking. Using the more conservative estimate for participation elasticity of -0.76 and the most recently available prevalence estimates, the GAO predicted that a 21-cent tax increase would result in a reduction of more than one-half million teenage smokers. Because deterrence in the teen years may result in lifelong abstinence from smoking, the health impact on this group is especially significant.

Projected responses to excise tax increases are subject to a number of potentially distorting influences, and estimates should be interpreted with caution. The level of uncertainty increases as we seek to generalize the results of previous studies to changing social and normative environments, varying levels of tax increases, and long-term impact on smoking. Recent empirical data on cigarette consumption trends may be helpful in validating short-term price response estimates. Several conceptual issues regarding the use of results from elasticity studies in forecasting price response are also summarized below.

Significant increases in the cigarette excise tax have occurred recently in the United States, Canada, and the State of California. From 1981 through 1984, the real price of cigarettes in the United States increased 27 percent, while per capita consumption declined 10 percent (Harris, 1987). In Canada, the real price of cigarettes rose 66 percent from 1982 to 1988, with an attendant 24 percent drop in per capita consumption (Canadian Council on Smoking and Health, 1990). Finally, preliminary data from California suggest that overall sales in California in the third quarter of 1989 dropped 10.5 percent from that in the third quarter of 1988 (James Howard, personal communication, 1990). The 25-cent-per-pack state tax increase implemented in January 1989 raised the price of cigarettes in California about 20 percent.

These declines in cigarette consumption reflect a substantially accelerated decline over the rate for previous years and are consistent with a price elasticity in the range of -0.36 to -0.50. However, the extent to which the declines may be attributed purely to the price increases cannot be precisely determined. The Canadian Council on Smoking and Health attributes only about half of the decline in consumption to the effect of the increase in cigarette prices.

Recent consumption trends, and how they have been interpreted, point to several of the difficulties involved in accurately measuring and predicting responses to price increases. There are many influences on smoking behavior that operate concurrently with changing levels of price, making it difficult to isolate specific effects. It is possible that more of the recent decline in smoking than is generally recognized is due to general societal trends. On the other hand, Harris (1987) suggests that the decline in smoking prevalence, particularly among lower income groups, might have been substantially greater if the real price of cigarettes had not declined during the 1970's.

Recent experience suggests that tax increases are not simply passed directly to consumers but may be accompanied by an additional percentage increase by the manufacturers, thus "multiplying" the impact of the tax increase (Harris, 1987). There has also been increased marketing and sales of low-cost generic and discount brand cigarettes (Adler and Freedman, 1990), a trend that may serve to partially offset the influence of a tax increase. The long-term impact of tax increases on consumption is less clear than the short-term response. It is also uncertain whether large increases in price have the proportionately equivalent effect of small increases.

#### Preferential Hiring And Promotion Relationship to Other Policies

A range of worksite policies and programs may potentially influence smoking behaviors. Rigotti (1989) outlines a continuum of worksite smoking policies that includes (1) no explicit policy, (2) environmental alterations, (3) designated smoking and nonsmoking areas, (4) total smoking bans, and (5) preferential or exclusive hiring of nonsmokers. This section considers only the fifth and most restrictive category. This does not imply that less restrictive policies do not also generate economic incentives for reducing cigarette consumption. Job opportunities may be constrained for those who resist applying for positions where restrictions are imposed. Among the costs of noncompliance with established worksite smoking policies is the threat of losing one's job—certainly an economic incentive. Some worksites have also developed financial incentive programs as part of their overall effort to facilitate smoking cessation among employees. These incentives typically involve small monetary rewards to employees who successfully maintain abstinence from smoking (Orleans and Shipley, 1982). Variations of this approach include the use of contests, prizes, and lotteries to increase the program's visibility and appeal. A number of programmatic approaches to worksite incentives are described in a workbook published by the National Cancer Institute (US DHHS, 1989c).

Walsh and McDougall (1988) identify several motivational concerns that underlie company smoking policies. The reasons for preferential hiring and promotion of nonsmokers appear somewhat different and more situation-specific than those given for on-site restrictions. Protection of the health and rights of nonsmokers in the workplace is a key component of worksite restrictions (Rigotti, 1989). However, the extension of policies to personal behaviors away from the worksite may be motivated more by economic considerations (Walsh and McDougall, 1988). Employers defend the practice of preferentially hiring nonsmokers because smokers incur higher costs to both the business and society (Action on Smoking and Health, 1989). Some occupations involve environmental exposures where employees who smoke are at a much greater health risk and thus not hired for this reason. Hiring restrictions have been imposed also for jobs that require high levels of physical fitness, such as for firefighters and police officers. Additionally, for occupations where respiratory functional decline caused by tobacco use can be confused with compensable occupational injury, employers have hired only nonsmokers to limit disability costs.

#### Prevalence and Current Trends

Recent surveys of employers suggest that the practice of hiring only nonsmokers is uncommon, occurring in only 1 to 2 percent of the businesses surveyed (Bureau of National Affairs, 1987; Peterson and Massengill, 1986; Swart, 1988). The Bureau of National Affairs report found little evidence that exclusive hiring practices are becoming more prevalent, despite growing implementation and acceptance of worksite restrictions. However, a more recent report (Action on Smoking and Health, 1989) cited evidence to suggest that the frequency of these practices is increasing. Hiring preferences, as opposed to absolute hiring restrictions, are more common. The Bureau of National Affairs survey found that 5 percent of the organizations surveyed gave companywide preference to nonsmoking applicants, and another 10 percent allowed individual supervisors to preferentially hire nonsmokers. It is possible that informal preferential hiring practices are substantially more widespread than the policy survey suggests. A poll by a New York recruiting firm found that 46 percent of the executives of large firms would choose a nonsmoker over an equally qualified smoker (Bureau of National Affairs, 1987).

Such informal preferences may also apply to promotion and firing decisions. Although Peterson and Massengill (1986) found that none of the companies surveyed indicated that they preferentially promoted nonsmokers, anecdotal evidence suggests such practices exist, although discreetly (Freedman, 1987). A similar situation may exist with regard to demoting or firing employees who smoke, even though companies that

hire only nonsmokers do not as a rule dismiss smokers employed prior to implementation of the hiring policy (Action on Smoking and Health, 1989).

Any increase in the prevalence of nonsmoker hiring policies is expected to be gradual. When businesses were asked to project whether they would have such a policy in place in the future, 3.8 percent predicted they would by 1990, and 6.6 percent by 1995 (Swart, 1988). There are several reasons for reluctance on the part of employers to implement preferential hiring policies. There is a perception that less restrictive measures are working well and that hiring restrictions are intrusive and go beyond normal employment practices. Businesses may not want to restrict their pool of available employees. Also, verification of smoking status of current and potential employees and decisions on how to respond to infractions are problematic and potentially costly. Guidelines by Action on Smoking and Health (1989) suggest that employers clearly state their policy to all applicants and that consequences of infractions be stipulated. Some employers have implemented biochemical or physiological testing to verify smoking status.

#### Influence of Hiring And Promotion Preferences

Although several formal evaluations of the effect of worksite smoking policies on smoking have been conducted, none have specifically examined the impact of preferential or exclusive hiring practices. Clearly, one potentially important contribution that such policies make is the message they convey about the changing social acceptability of smoking. Formal policies against hiring smokers are still relatively uncommon but may be highly visible and attract considerable media attention. The more direct impact of such policies is expected to occur through the economic incentive to quit smoking provided by the policy. If employment is contingent on quitting smoking, some potential applicants might be motivated to quit smoking rather than settle for some other job. Whether or not this happens depends on a number of considerations, including the availability of other employment opportunities and the strength of the individual's propensity to smoke.

#### Legal Issues

The legal right of employers to preferentially or exclusively hire nonsmokers is generally recognized. Federal and state statutes prohibit discrimination on the basis of race, religion, national origin, and, in most circumstances, age and sex. In some situations, it is also unlawful to discriminate on the basis of sexual orientation, political affiliation, marital status, citizenship, and physical or mental handicap (Myers, 1990). Aside from these attributes, employers in most situations have the right to make hiring decisions on whatever basis they choose, including smoking status.

On the forefront of occupations experiencing establishment of nonsmoker hiring policies are emergency services. A firefighter in Oklahoma who was dismissed from his job when observed smoking off duty challenged his dismissal, but the employment policy of the fire department was upheld in Federal court in 1987. Another challenge to a nonsmokers-only hiring policy occurred when the application of a New York woman for employment in a jewelry store was rejected. In this case, the applicant claimed that she was discriminated against on the basis of a handicap, namely an addiction to smoking. Although New York state law classifies addicts of certain drugs as handicapped, no mention is made of tobacco. Even so, the case is proceeding after it was determined by a state board that there was probable cause to suspect that unlawful discrimination had occurred.

Additional legal challenges to preferential hiring policies are probable. The American Civil Liberties Union opposes such practices except where the smoking status of applicants or employees can be shown on a case-by-case basis to interfere with job performance. However, no actions by the American Civil Liberties Union to date have been initiated against employers who refuse to hire smokers. Additional challenges to nonsmoker hiring practices may be brought on the basis that they are discriminatory to blacks, because of a higher smoking prevalence among blacks. One other potential focus of legal debate on preferential hiring practices is the invasion of privacy issue, although this aspect of such policies has so far gone unchallenged.

Two additional caveats may apply to employment policies that favor nonsmokers. The first applies to any workplaces that are covered by collective bargaining agreements with labor unions. Most cases in which unions have confronted management on smoking policies have focused on workplace restrictions. However, collective bargaining agreements may also pertain to restrictions on eligibility for employment. Efforts by the Manville Corporation, a Texas asbestos manufacturer, to hire only nonsmokers and ban workplace smoking have been stymied by litigation instigated by the International Machinists Union. Although in some cases management has successfully defended its nonsmoker-hiring policies, the general recommendation for employers is to develop and impose hiring policies and smoking restrictions in consultation with the unions involved and in accordance with current collective bargaining agreements (Action on Smoking and Health, 1989).

The second situational limitation on the legal right of employers to hire only nonsmokers occurs when state or local laws prohibit such practices. In 1989 legislation was passed in Virginia that prohibits state agencies from requiring employees

to be nonsmokers. Private employers are not affected by the legislation, nor are agencies prevented from implementing workplace smoking restrictions. A similar bill in the State of Maryland, applicable to both public and private employers, was defeated in 1989.

#### Differential Insurance Premiums Current Status

Substantial evidence that smoking is firmly associated with reduced longevity, health care costs, and damage to property has accumulated over the past 45 years. This evidence has elicited varying degrees of response from the corresponding major components of the insurance industry—life, health, and property. Before the release of the 1964 Surgeon General's Report, no major insurer of any type offered premium reductions to nonsmokers. Now almost all life insurance companies provide nonsmoker discounts, whereas only a small but growing number of health and property insurers do so. This section examines the development and current status of differential premium rates for smokers and nonsmokers for each of the three major arms of the insurance industry. To the extent that these differentials are visibly passed on to individual consumers, they may provide an economic incentive not to smoke. Premium differentials could be labeled as either nonsmoker discounts or smoker surcharges; the net premium costs to smokers and nonsmokers would be the same. However, for both historical reasons and marketing purposes, the term "nonsmoker discount" is generally used.

Although life insurance companies began to introduce nonsmoker discounts as early as 1965, adoption proceeded slowly until 1979. In that year, a definitive actuarial study by State Mutual Life Assurance revealed a substantial and statistically significant mortality difference between smokers and nonsmokers. Collaborative evidence provided by other companies soon followed. By 1984, the National Association of Insurance Commissioners had developed formal guidelines for setting differential premium rates for smokers and nonsmokers, which were subsequently incorporated into practice in most states. Currently, the vast majority of companies provide nonsmoker discounts on individual policies. The size of the discounts varies across ages and gender; average discounts are in the range of 12 to 22 percent (US DHHS, 1989a).

The situation for health insurance, where providers have been slower to adopt nonsmoker discounts, is considerably more complicated. Most health insurance is purchased as group coverage, where the health status and risk factors of individuals typically are not considered. Furthermore, actuarial data on the health care cost differentials of smokers and nonsmokers have not been as complete and readily available as for mortality differentials (US DHHS, 1989a). Administrative costs and the problem of verifying the smoking status of individuals covered

by group policies may also contribute to the reluctance of the industry to provide discounts. Despite a National Association of Insurance Commissioners resolution (1985) supporting premium differentials in both group and individual policies and an Action on Smoking and Health (1987) special report that questioned the legality of not differentiating, only about 15 percent of individual policies offer nonsmoker discounts. Even fewer group plans do. Individual policies carry discounts that range from 3 to 15 percent. Group plan differentials are usually provided on the basis of the percentage of nonsmokers in the group and offer discounts of a few percentage points to groups below a specified smoking prevalence level.

Nonsmoker discounts in property and casualty insurance are also relatively uncommon. This situation exists despite solid evidence that smoking materials are responsible for a significant percentage of house fire property damage and fire-related deaths and that smokers have more vehicular accidents than nonsmokers (US DHHS, 1989a). The Farmer's Insurance Group was the first company to offer nonsmoker discounts and as of 1987 was still the only major insurer to offer them on both homeowner and automobile policies. Discounts on homeowner policies range from 3 to 7 percent and on automobile policies from 10 to 25 percent. Recently the Hanover Insurance Company increased its nonsmoker discount for automobile policies from 5 to 10 percent. The difficulty of verifying smoking status, as well as prohibitory regulations in certain states, have deterred more companies from adopting discount policies.

State insurance commissions and legislatures have prohibited certain practices that offer premium differentials because they were deemed discriminatory. However, the National Association of Insurance Commissioners has actively sought to encourage state governments to remove legal barriers to nonsmoker discounts and has facilitated the collection of actuarial data to help justify the practice. In the future, a willingness on the part of state legislatures and insurance commissions to require the availability of differentially priced policies may result from these efforts.

One additional insurance industry practice that indirectly offers a financial incentive to quit smoking is the coverage of costs for smoking cessation programs. This coverage is currently uncommon, and the future growth of such policies is uncertain. Only 11 percent of carriers surveyed in 1985 provided benefits for smoking cessation programs (US DHHS, 1989a). Employers have absorbed some of the burden for providing cessation resources, and more may be expected to do so if discounts for group health insurance policies continue to become more widely available.

#### Effects of Premium Differentials

Similar to the situation regarding preferential hiring, no empirical studies have assessed the impact of differential insurance premiums on smoking. Until such studies are conducted, expectations must remain speculative. Premium differentials may reduce smoking by providing both economic incentives and social or educational influences. For several reasons, premium differentials will probably provide less economic incentive for not smoking than direct increases in the price of cigarettes. Their impact is acute only at the time the policies are paid, and even then it may not be made clear to consumers that smokers are paying more. In many circumstances, smokers will have the option of simply switching to another policy or provider that does not differentiate. Health insurance premiums are often paid entirely by employers, although increasing efforts by employers to reduce their health insurance costs may result in more smokers having to pay extra for health insurance.

The role of the insurance industry in providing additional awareness and support for the declining social acceptability of smoking may be just as powerful as any economic incentives it provides. Being asked about one's smoking status when completing insurance forms is yet another reminder of the potential personal health and economic consequences of smoking. Health maintenance organizations may be especially inclined to provide educational reminders and resources for smoking cessation, although adoption of such efforts is also advocated for the larger community of health care providers (S.R. Cummings et al., 1989).

#### An Overview Of Economic Incentives

There are several aspects of the use of economic incentives to discourage smoking that have raised ethical concerns about their fairness and appropriateness. The regressivity issue concerning excise taxes has surfaced repeatedly and is a basis for opposition to proposals to increase taxes on cigarettes. A regressive tax is defined as one where the proportion of individual's income consumed by the tax is inversely related to income level (Fusfeld, 1982). Cigarette taxes appear to be highly regressive (Citizens for Tax Justice, 1988; Toder, 1985), although Harris (1985) suggests that the regressivity issue has been exaggerated. Proponents of increasing excise tax rates, although aware of the regressivity issue, weigh this concern against the expected improvements in health status and longevity resulting from the reduced prevalence of smoking. They also note that the lower income groups, where the burden of smoking-related disease is greatest, are also expected to show the greatest response to a price increase (Townsend, 1987).

Many other elements have been introduced into the debate over the fairness of economic incentives. Among these are ethical concerns about paternalism, victim blaming, and fair distribution of costs. The current racial and socioeconomic disparities between smokers and nonsmokers has elicited charges that economic incentive policies are racist and elitist. The accuracy of projected effects of a tax increase has been questioned, and little empirical evidence is available on the effects of the other economic incentive strategies. Potential consequences include a lack of employment opportunities and affordable insurance for those who are unwilling or unable to stop smoking.

Despite the numerous arguments raised in opposition to economic incentive policies, there is broad support for these approaches. Increases in the cigarette excise tax are advocated by numerous health organizations, including the American Heart Association, American Lung Association, American Cancer Society, American Public Health Association, and American and Canadian Medical Associations. Several proposals have been offered to mitigate at least some of the previously raised ethical concerns. These suggestions merit serious consideration and further reflect the importance of a coordinated, multifaceted approach to smoking and tobacco control. For example, Toder (1985) and Warner (1986b) argue that potentially negative effects of excise tax regressivity could be offset by making other aspects of the tax structure more progressive. Earmarking of tobacco tax revenues for health care and tobacco cessation and education programs may reduce the perception that smokers are being victimized or exploited. A 1987 American Medical Association poll (Harvey and Shubat, 1987) showed that a majority of smokers support an increase in the cigarette excise tax if the revenues are earmarked for Medicare costs. In California, 75 percent of the estimated \$600 million generated in the first year of the Proposition 99 tax increase is designated for health care, drug education, and research. Increased affordability and availability of smoking cessation resources and programs help remove economic and logistical barriers to quitting and also contribute to an atmosphere of positive support and reinforcement for those trying to quit.

The economic incentive strategies examined here focus on methods that increase the cost of smoking for consumers. Another approach is to apply economic inducements and policies to the supply side of the smoking problem, which includes agricultural practices and policies, cigarette manufacturing and distribution, and advertising (Walsh and Gordon, 1986). Initiatives that may reduce smoking by affecting this side of the smoking equation include (1) elimination of the tobacco support program (Warner, 1988), (2) agricultural

policies that promote and subsidize alternative crops (Millo, 1985), (3) elimination of tax deductions for tobacco advertising (US DHHS, 1989a), (4) further restrictions on advertising (Warner et al., 1986), and (5) tighter controls on the distribution and sale of tobacco products (DiFranza et al., 1987). The political influence of the tobacco industry has undoubtedly impeded the implementation of these initiatives, but the increasing political influence of the antismoking movement enhances the opportunity for a broad spectrum of antismoking legislation. The potential impact of policies to restrict advertising and actively support the agricultural transition to other crops extends beyond their direct impact by complementing and reinforcing other antismoking efforts. For example, economic inducements and educational efforts might be even more effective when seen as part of a broader and more congruous Federal policy to reduce smoking and improve health.

## CONCLUSIONS

- The targets of recent interventions to control tobacco use are social networks that shape the attitudes of individual smokers and nonsmokers, including media, health care providers, worksites, and schools.
- The use of media in tobacco control includes providing information on the risks of tobacco use and dangers of policies that promote tobacco use, motivating smokers to stop and others to not start, and conducting cessation programs or recruiting smokers into treatment programs.
- Health care providers should not only intervene with their smoking patients but also be agents for social change.
- Restrictions on smoking in the worksite and other locations change the social acceptability of smoking and may increase the number of individuals who try to quit and who have long-term success after cessation.
- Comprehensive smoking control strategies are best implemented at the local level and can be implemented through formation of coalitions of established community groups.
- Most adolescent smokers have little difficulty in purchasing cigarettes, even when these purchases violate local laws. Increasing the barriers to cigarette purchases by minors is important in strategies to prevent the initiation of regular tobacco use.
- Economic incentives that may reduce the consumption of cigarettes include increasing the excise tax on tobacco products; preferential hiring and promotion of nonsmokers; and increasing the cost of life, health, and other forms of insurance for smokers.



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## Chapter 6

# Interdependence and Synergy Among Smoking Control Activities

### INTRODUCTION

Efforts to control tobacco use have employed a wide range of tactics and techniques to reduce the prevalence of smoking. Traditional approaches to smoking control have focused on the individual, with less attention to the broad social context within which the individual acts.

More recently, a number of researchers have recognized that local values, norms, and behavior patterns are significant in shaping an individual's attitudes and behaviors (Abrams et al., 1986; Farquhar et al., 1977; McAlister et al., 1982; Puska et al., 1985). Rather than emphasizing changes by individuals, the newer approach argues that permanent, large-scale behavioral change is best achieved through changing standards of acceptable behavior; that is, through adoption of different norms for health-related behavior (Abrams et al., 1986; Farquhar, 1978; Farquhar et al., 1985a; Syme and Alcala, 1982; Van Parijs and Eckhardt, 1984).

In the past 15 years, a number of major health-promotion initiatives have used a community approach to change behavior (Abrams et al., 1986; Elder et al., 1986; Farquhar et al., 1985b; McAlister et al., 1982; Mittelman et al., 1986; Puska et al., 1985; Tarlov et al., 1987). Most of these efforts addressed multiple risk factors in cardiovascular disease, with goals of changing individual subjects' behavior with regard to smoking, diet, and screening for health problems. The majority of such projects reflected the need to change the social context of their communities, recognizing that the environment has a significant role in facilitating or inhibiting the adoption of new behaviors (Farquhar et al., 1977; Farquhar et al., 1985b; McAlister et al., 1982; Puska et al., 1985). Some researchers also have discussed the importance of changing community norms. Planning interventions that capitalize on the inherent interdependence and synergy of a system is likely to yield a maximum effect.

In this chapter, (1) a conceptual framework for a comprehensive, synergistic approach to smoking control is presented; (2) pertinent data in support of such an approach are reviewed; (3) examples are presented to illustrate how interventions have built and can build on the interdependence and synergy



**CONCEPTUAL  
FRAMEWORK**

among them; and (4) synergistic approaches for three specific target populations—women, black Americans, and Hispanic Americans—are reviewed.

Individuals do not act in a vacuum; rather, they are greatly influenced by the social environment in which they act. A smoker often responds to environmental cues when deciding to smoke or not smoke. For instance, a work break, the end of a meal, and exiting from a no-smoking facility are situations that provide the smoker with cues to smoke; while attending a religious service and working in designated no-smoking areas are examples of cues that inhibit the smoker's behavior. Many cues have their origins in rules about acceptable behaviors—norms (Robertson, 1977). Changing the environment that surrounds the smoker involves changing the prevailing norms.

In concept, the social environment may be considered a system with related and interdependent parts that serve to maintain the whole. The system includes many components, or subsystems, that carry out the activities required to keep the system viable; among these subsystems are the political, economic, and educational institutions that ensure governance of, resources for, and socialization into the system. The system is not a simple aggregation of its component parts; rather, it is a unique structure that includes all the parts and the interdependencies that connect the parts (Von Bertalanffy, 1962). The system also provides the context for all activities, including making choices about behaviors. The social environment system is based on some degree of cooperation and consensus on social norms (Ashby, 1958; Boulding, 1978), and individuals generally act within the parameters of the system.

Social norms change along with the system to provide new rules of conduct to help maintain the reformed system (Robertson, 1977). An example of this can be seen in the emerging norms related to tobacco use. Technical changes—recognition of the dangers of smoking cigarettes and of inhaling secondhand smoke—have led to restrictions on public smoking, and as this secular trend accelerates, smokers find it is no longer appropriate to light up in all settings.

Factors that promote continued tobacco use are still found at many levels in the system, though. The political subsystem provides price supports for tobacco growers and thus affects the economic subsystem. Together, the political and economic subsystems contribute to the development of public and private resources that expand the tobacco industry's capability to further promote its products. In addition, tobacco industry representatives are adept at using the communication subsystem to relay messages that promote acceptability for tobacco use (Leventhal et al., 1987; Tye et al., 1987; Warner, 1986a;

White, 1988). An important factor is the addictive nature of tobacco (US DHHS, 1988), which helps to maintain a high level of demand for the product.

Conversely, there are system factors that inhibit the use of tobacco. The political sector has publicly endorsed and supported some restrictions on certain tobacco industry activities, most notably in the area of distribution and promotion of products to minors (DiFranza et al., 1987; Tobacco-Free America Project, 1988; US DHHS, 1989). Excise taxes on tobacco products have some effect in the economic sector. When cigarette taxes are portrayed as "sin" taxes (Harris, 1982; Tobacco Institute, 1988), a message about smoking behavior is disseminated through the system. The economics of such taxation also may affect the prevalence of smoking: estimates indicate a drop of about 2 percentage points in the prevalence of adult smoking for every 8-cent increase per package of cigarettes (Harris, 1982; Lewit and Coate, 1982; Warner, 1986b). Another subsystem, the scientific sector, has published thousands of studies linking ill effects to tobacco use, thereby providing yet another force against smoking.

The net environmental effect of the forces influencing tobacco use has been a gradual move away from the free use of tobacco and toward restrictions on its use. In the past 20 years, tobacco advertising has been restricted to media other than radio and television (Whiteside, 1971); 41 states have implemented restrictions on smoking in public places (US DHHS, 1986); all states have enacted cigarette taxes (US DHHS, 1989); and many other restrictions on tobacco sales and use have been legislated (Pertschuk and Shopland, 1989).

There is little doubt that environmental changes have an effect on the smoking habits of individuals. The 1964 Surgeon General's Report, for example, led to a significant change in smoking prevalence (US DHEW, 1964; Warner, 1985). A similar effect was seen when the Federal Communications Commission required "equal time" for antismoking messages on radio and TV to match the time allotted for cigarette commercials (Warner, 1985). "Clean air" laws, enacted recently around the country, also may have had an effect on prevalence as smokers find it more difficult to smoke in public places.

As the forces working toward restrictions on tobacco use multiply, a type of synergy—beneficial cooperation among various sectors of the system—develops. To the extent that relations among the sectors are harmonious and oriented toward a common goal, the synergy that develops produces a net effect of the combined forces that is greater than the sum

## STUDIES OF ENVIRONMENTAL CHANGE

of their separate effects. Ultimately, the synergy of multiple forces supporting tobacco restrictions should lead to a societal norm in which tobacco use is not acceptable.

Empirical research addressing how various changes in tobacco control relate to the social environment and to the prevalence of tobacco use has been largely retrospective and observational. Few experiments have been conducted in which the multiple social forces that promote tobacco restrictions have been manipulated.

The Stanford Three-Community Study (Farquhar et al., 1977) used the communication sector (media) to deliver messages about smoking cessation. Although success was limited, there appeared to be some synergy between the media messages and intensive assistance with smoking cessation provided to individuals at high risk for cardiovascular disease (Meyer et al., 1980). In another community, media messages alone were used, and the observed effect was not significantly greater than the change seen in a control community that received neither media messages nor face-to-face intervention (Farquhar et al., 1981).

Investigators of the Australian North Coast study found significant smoking reduction among all smokers through a combination of media programs with community programs (Egger et al., 1983); again, that effect was not seen in a community that received only media interventions. Similarly, the Finnish North Karelia Project showed a significantly greater decrease in smoking in a community that received multichannel stop-smoking activities than in a control community that received no intervention (Puska et al., 1983). A Swiss national study used media, public policy changes, and a community organization approach to achieve significantly higher rates of smoking cessation in intervention communities than in the control communities (Gutzwiller and Schweizer, 1983). Three ongoing community studies—the Minnesota Heart Health Project (Jacobs et al., 1986), the Pawtucket Heart Health Program (Elder et al., 1986), and the Stanford Five-City Project (Farquhar et al., 1985)—are projects similar to those above; however, their results have not yet been reported.

## SYNERGISTIC EFFECTS AMONG SELECTED INTERVENTIONS

Additional examples of the effectiveness of multiple intervention subsystems and the effects of synergy can be seen in at least three specific areas: media coverage of antitobacco events, policy changes at worksites, and antismoking messages conveyed by physicians. The following paragraphs briefly describe the interactions and interdependencies that lead to a presumably synergistic result.

## Media Coverage Of Antitobacco Activities

Several advocacy techniques have been used in efforts to obtain media coverage of antitobacco events in two major areas: promotional activities and cessation activities. A small but influential group of advocates has developed simple techniques to attempt to gain media attention. A common tactic is to borrow some aspect of a prosmoking promotion and endow it with an antismoking message; for example, the "Emphysema Slims" tennis tournament was hosted to counter a "Virginia Slims" tournament (US DHHS, 1988). Similarly, the media are attracted to conflicts. In a "monster truck" rally, one of the drivers chose to decorate her truck with no-smoking symbols; she was prevented from driving her decorated truck because the event was sponsored by a tobacco company (Doctors Ought to Care, 1990).

The media also respond to the positioning of an issue around another extant issue. Several recent news events, for example, were amenable to reframing in terms of tobacco information. When cyanide was found in Chilean grapes in March 1989, news releases related the fact that cyanide is present in tobacco smoke (DeNelsky, 1989). Advocates of smoking control also noted the apparent contradiction in a tobacco company's support of a dance troupe (Smoking Control Advocacy Resource Center, 1989). Similarly, a number of editorials pointed out that the amount of benzene in Perrier water taken off the market was only a fraction of the amount of benzene in tobacco (Smoking Control Advocacy Resource Center, 1990).

It is difficult to determine whether such media coverage has any effect on smokers. It is likely, however, that such coverage reinforces and helps to solidify a nonsmoking norm that already has substantial support.

It is easier to draw conclusions from media coverage of cessation activities. Some investigators (Bettinghaus, 1988; Flay, 1987) have examined the efficacy of media promotions for use of a smoking cessation hotline (Anderson et al., 1989), use of self-help cessation materials (Jason et al., 1988), and participation in other smoking cessation programs (Cummings, 1987; Danaher et al., 1984). Although the results vary, there is a strong trend for increased participation in smoking cessation activities when media messages are available; similarly, evidence suggests that smokers are more likely to stop smoking when the two activities are combined than when each activity is presented alone (Flay, 1987).

Media control and smoking control activities are interdependent in that media cannot operate without activities and events to cover, and cessation activities and motivation messages to stop smoking make significant news only rarely (e.g.,

when new research findings are released). When tobacco-related issues are framed in a newsworthy manner, both media and smoking control groups benefit. Furthermore, smokers benefit because they are made aware not only of their habit and the opportunity for changing that habit but also of the ways in which they are manipulated into tobacco use. Such insights may motivate them to look more carefully at their smoking.

Over time, the antismoking messages may be adopted into the normative structure of society, and notions about the impropriety of tobacco vendors' promoting cultural, political, sporting, and other events will become norms.

#### Worksite Policies For Smoking Control

Restrictive smoking policies are being implemented increasingly in both public and private workplaces. All Federal workplaces are now subject to policies that restrict smoking to designated areas (US DHHS, 1989). In addition, 31 states have laws restricting smoking in public workplaces, and many other states have similar restrictions through executive actions (US DHHS, 1989). The numbers are equally impressive for private workplaces: almost 300 cities and counties have mandated formal policies about smoking in public and private workplaces. Surveys reported in 1986 (Bureau of National Affairs) and 1987 (US DHHS) placed the prevalence of restrictive smoking policies in private workplaces at 30 percent and rising rapidly, since the majority of workplaces surveyed that did not have a policy had at least a plan to institute one in the near future (US DHHS, 1986 and 1989).

The effect of worksite smoking policies on the attitudes of smoking employees provides important information on the acceptance or nonacceptance of this normative change. Results from a number of studies (Brown et al., 1988; Thompson et al., 1987; US DHHS, 1987) showed that smokers as well as nonsmokers responded well to smoking restrictions at work. Both groups reacted more favorably to the policy after it was implemented than before (Petersen et al., 1988; Rigotti et al., 1986; Rosenstock et al., 1986), suggesting that conversion to the new norm was accomplished easily.

Although data are somewhat equivocal, experts are becoming more convinced that worksite smoking policies have some effects on employees' smoking (Petersen et al., 1988; Rosenstock et al., 1986). Studies of employee participation in workplace smoking cessation programs that are offered along with implementation of a smoking control policy indicate that, for at least some workplaces, policy implementation increases enrollment in cessation activities (Martin, 1982; Walsh and McDougall, 1988).

The interdependence of worksite policies and smoking cessation activities is clear: when workplace policies restrict smoking, smokers will reduce the amount they smoke during the workday. Employers benefit in the long run by increased productivity and decreased costs for cleaning and insurance. Nonsmoking employees benefit by reduced exposure to environmental tobacco smoke, whereas smokers benefit in terms of health (if they achieve cessation) and support in stopping their habit. Where restricted smoking policies are implemented, worksite norms are likely to change to advocate nonsmoking, thus offering smokers an ongoing incentive to quit and to stay abstinent.

The synergistic effect between worksite policies and the smoker is that the employer action may propel the smoker toward cessation. Nonsmoking employees are also likely to support nonsmoking and may provide repeated and continuing impetus for smokers to quit. Smokers may benefit because some of the cues for smoking are controlled, making it easier for them to avoid the practice. Over time, the new nonsmoking norm may become entrenched in the workplace, providing smokers with yet another prompt to stop smoking.

#### Physician Actions For Tobacco Control

Physicians have regular, recurring opportunities to offer smoking cessation messages to their patients, because most smokers (70 percent) visit a physician annually (Ockene, 1987). Smokers listen to their physicians, and a sizeable number of smokers report that their physicians have advised them to stop smoking (Ockene et al., 1987).

The advice of a physician is particularly effective when it is part of a general office system that provides regular messages about quitting smoking and offers assistance with cessation efforts (Ockene, 1987; Wilson et al., 1987). Chart identification, use of an office coordinator who asks about smoking status, and a regular plan for advising the patient on the specifics of smoking cessation are more effective in helping patients achieve cessation than simply asking about smoking. The regular physician messages may be enhanced also by the environment of health care offices: a no-smoking office policy, amplified by posters, cessation information, and other cues for nonsmoking, provide strong normative support for cessation.

In addition to physicians' having an ability to affect individual smokers, they are powerful lobbyists for smoking control activities. Through their professional associations (American Medical Association, American Academy of Family Physicians, and others), physicians present a formidable lobby to persuade policymakers to control the use of tobacco. Historically, the professional associations have worked toward tobacco

control in a number of areas, especially in smoke-free environments and control of advertising directed to youth. Physician organizations such as Doctors Ought to Care provide regular lobbying at the national, state, and local levels to restrict tobacco use.

As with the other examples, the synergistic effect of physicians' messages and other smoking control activities is found in the repeated and pervasive messages to smokers to modify their behavior. In addition, the health care environment for the smoker promotes nonsmoking as the acceptable behavior.

In each of the three examples above, there appears to be an interdependence and synergy between the sector employed for control of tobacco use and the other societal subsystems. In addition, each sector seems to be contributing toward the development of increasingly stronger nonsmoking norms. Although empirical substantiation for such assertions is weak, a number of current research efforts in smoking control (for example, the Community Intervention Trial for Smoking Cessation [COMMIT] and the American Stop Smoking Intervention Study for Cancer Prevention [ASSIST]) are expecting synergy in planning interventions, and they may provide more information on the empirical validity of this approach.

While the overall prevalence of smoking has gone down significantly over the past 20 years, the prevalence is still high among those in our society who are most disadvantaged—women of all races, black people, and Hispanics who have the lowest education level and incomes. This is not accidental. The cigarette industry spends \$2.5 billion per year to convince minority groups, women, and young people that nicotine—an addictive drug—is their ticket to "elegance, power, confidence, maturity, and desirability" (Tuckson, 1989). Tobacco companies spend \$1.4 million per year on advertising in Hispanic communities, and in black communities they spend \$5 million per year on billboards alone (Davis, 1987). Surveys in low-income communities have shown that they are saturated with billboards promoting cigarettes (Tuckson, 1989).

The presence of the tobacco industry in the lives of minorities and women of all races goes well beyond advertising. The industry is an important funder of minority organizations, publications, and events, and it has even managed to ally itself with civil rights issues by equating freedom to smoke with the civil freedoms guaranteed by the Bill of Rights. The National Cancer Institute has funded projects that aim directly at these groups, and communities are beginning to build coalitions to combat the cigarette companies when their targeting of particular populations becomes apparent.

#### Smoking Among Women Magnitude of the Problem

Following are discussions of the magnitude of the problem for each of three groups (women, blacks, and Hispanics), as well as a consideration of barriers that racial minority groups and women must confront in smoking cessation.

Before World War II, smoking was primarily a male behavior. In the late 1930's and 1940's, women began to take up cigarette use until the prevalence of smoking among women peaked at 32 percent from the mid-sixties to the mid-seventies (US DHHS, 1989). Since that time, smoking rates have declined for both sexes, but the rate of decline among women has been slower than that among men. In 1986, 28 percent of adult women smoked compared with 33 percent of adult men (Morbidity and Mortality Weekly Report, 1987). If the differential rate of decline among men and women continues, by the end of the century more women than men may be smokers.

While fewer males have taken up smoking in recent years, the rate of initiation has remained fairly constant among females (Fiore et al., 1989). The situation among disadvantaged women, however, is even worse. From 1979 to 1985, the smoking prevalence among women who were less educated and had lower socioeconomic status (SES) actually increased from 40 percent to 44 percent.

Women tend to underestimate the health risks that they incur because of cigarette smoking (Sorenson and Pechacek, 1987). It has been speculated that the more rapid decline in smoking among men relative to women in the 1960's was due to the Surgeon General's Report linking smoking with lung cancer and heart disease. At the time, these diseases were seen as more relevant for men than for women. Since that time, the disease rates for women have increased markedly. While mortality from breast cancer has not changed in recent years, mortality from lung cancer among women has risen dramatically. Lung cancer now exceeds breast cancer as the largest cause of cancer deaths among women (American Cancer Society, 1990).

Concern about physical appearance may be another barrier to smoking cessation by women. Quitting smoking is often accompanied by significant weight gain (Rodin and Mack, 1984), and women are more likely than men to report that fear of weight gain keeps them from giving up cigarettes (US DHHS, 1980; Waldron, 1988).

Female adolescents who smoke have been shown to be more self-confident, socially skilled, and outgoing than those who do not. Girls seem to adopt smoking not because they are pressured to, but because they seek to identify themselves as independent, successful, and glamorous—precisely the image

#### Barriers to Smoking Cessation

#### Current Intervention Research

#### APPROACHES TO TOBACCO COMPANIES' TARGETS

**Channels for  
Reaching Women**

projected by cigarette advertisers. Finally, smoking is one of the significant ways that women cope with stress, particularly the stress of being a mother of small children (Blener, 1987).

The health care system is a good channel for smoking cessation efforts, as women tend to be high utilizers of health services. The fact that many women quit smoking during pregnancy suggests that the prenatal period provides a good opportunity for intervention. Public health clinics and neighborhood health centers that serve disadvantaged groups should make a special effort to convey the importance of quitting to their clients.

There are many magazines directed to women specifically. Counteradvertising (i.e., advertising designed to undermine the goals of tobacco advertising) in such magazines and/or convincing them to refuse to advertise cigarettes would reduce the association between attractiveness and smoking that is so prevalent in the media. At least two magazines, *Ms.* and *Good Housekeeping*, refuse to take cigarette advertisements. When tobacco companies are found to be targeting women, as in the recently revealed campaign to market Dakota cigarettes to a specific subgroup of women, influential groups such as the National Organization of Women may be willing to mobilize to counter the tobacco industry's promotional activity.

Many supermarkets and food stores have become involved in efforts to promote healthy choices by labeling foods that are low in cholesterol and/or high in fiber. These stores are often willing to disseminate information about the health risks of smoking (Hunkeler, et al., 1990). Efforts could be made by community organizers to discourage sales of cigarettes by food stores and sales of cigarettes to minors.

**Content of Messages**

Three messages about smoking may be particularly relevant in campaigns directed to women: (1) smoking is as much of a health risk for women as it is for men; (2) quitting smoking promotes the health of children; and (3) the possibility of being slimmer is not important enough to risk the health dangers of smoking. Messages about how to acquire social support from family members, friends, and coworkers may also help women to quit smoking.

**Smoking Among  
Blacks  
Magnitude of the  
Problem**

Black Americans have the highest smoking prevalence rates: 35.4 percent of black adults smoke—40.6 percent of black men and 31.5 percent of black women (Fiore et al., 1989; US DHHS, 1988). Blacks suffer the Nation's highest rates of morbidity and mortality from smoking-related diseases, including cardiovascular disease and lung cancer (Cooper and Simmons, 1985; US DHHS, 1985 and 1988). Cigarette smoking is a major contributor to the short life expectancy of inner-city black men (McCord and Freeman, 1990; Rivo et al., 1989).

**Barriers to  
Smoking Cessation**

Sociodemographic factors associated with smoking among black people are similar to those for the U.S. population as a whole. They include lower income, less education, blue-collar occupations, unemployment, male gender, and unmarried status (Orleans et al., 1989b; US DHHS, 1988; Warnecke et al., 1978).

Although the rate of smoking initiation is decreasing, and the ratio of quitting is increasing at similar rates for blacks and whites, blacks currently have a lower quit ratio (defined as the proportion of smokers who have quit). Quit ratio estimates range from 32.9 percent to 38.8 percent for blacks and from 47.1 percent to 49.3 percent for whites (Fiore et al., 1989; US DHHS, 1990). Past survey data suggest that black smokers may try to quit as often as whites, but they succeed less often (US DHHS, 1985).

Among blacks, several high-risk groups deserve special attention: (1) black women, because of the unique risks associated with smoking during childbearing years, and because their smoking rate is declining more slowly than that of black men (Fiore et al., 1989; Marcus and Crane, 1987); (2) smokers with less than a high school education because they are quitting at the slowest rates (Pierce et al., 1989); and (3) black men in blue-collar and service occupations because their smoking rates may exceed 50 percent (US DHHS, 1985). Special efforts are needed also to reach the chronically unemployed, who have high rates of smoking and may not be active in church and community groups (Lemann, 1986).

For black people, barriers to quitting smoking include reliance on cigarettes as a way of coping with the life stress and social disadvantage related to low SES and pervasive discrimination, limited access to health care in general and to smoking-related services and resources in particular, and limited confidence in their ability to quit (Hunkeler et al., 1990). A study of smoking among black people in Richmond, California, showed that more than 90 percent knew that smoking was harmful to health, but only 27 percent thought they could quit within the year (Hunkeler et al., 1990). Norms in black communities may actually encourage smoking. Many blacks regard other problems such as drugs, unemployment, and crime as having a higher priority than smoking. Powerful advertising tailored to black consumers not only glamorizes and legitimizes smoking but also downplays the health risks (Blum, 1989).

Fewer blacks (54 percent) than whites (70 percent) report a physician's office as their usual source of care. Twice as many blacks as whites say they receive their regular medical care from hospitals, public health clinics, and emergency rooms. Fewer

blacks than whites receive medical advice to stop smoking (Marcus and Crane, 1987; US DHHS, 1985).

Stronger smoking norms and tobacco advertising influences in black communities help to sustain a high smoking rate. Black-targeted tobacco advertising has become increasingly predatory and pervasive. The tactics include extensive cigarette advertising in black print media; increased billboard and point-of-purchase cigarette advertising in inner-city neighborhoods; tobacco company sponsorship of sports, civic events, and entertainment and cultural events important to the black community; and well-publicized philanthropic support of black causes and organizations (Blum, 1989; Cummings et al., 1987; Tuckson, 1989).

#### Channels for Reaching Black Smokers

Lasting change in individual smoking behavior requires changing the social and cultural context in which smoking occurs by integrating program components into many existing communication channels (Hunkeler et al., 1990). These communication channels include the health care system, black-focused mass media, churches, voluntary health organizations, fraternal and mutual aid organizations, workplaces, unemployment offices, job training programs, retail establishments, families, and neighborhood and tenants' organizations (Orleans et al., 1989b).

These channels include two types of organizations that might be mobilized to reduce black smoking—those that reach black populations easily, such as black churches, black fraternal and mutual aid organizations, and neighborhood and tenants' organizations; and those that have health and smoking on their agendas already, but are not focused on the black population, such as voluntary health organizations (e.g., American Cancer Society, American Heart Association, American Lung Association). To involve both types of organizations in the reduction of smoking among black people requires convincing black organizations to take up smoking as an issue (despite their other pressing priorities) and convincing the voluntary health organizations to produce materials that focus on blacks. Any successful effort to reduce smoking among blacks requires strong black leadership. Unfortunately, at this time many of the organizations in black communities do not have the resources to add smoking to their list of priorities. Enlisting the aid of those organizations requires time. Many of the organizations that deal with smoking, such as the lung association and the cancer society, are just beginning to focus more heavily on low-income and minority smokers.

If quitting smoking can be linked to other difficult problems faced by black communities, such as unemployment, quitting smoking might be more of a priority. For example, if

it could be shown that nonsmokers are more attractive job candidates, people might be more motivated to quit. If job training programs and unemployment offices distributed self-help materials and/or offered a smoking cessation component to their training, unemployed black smokers might be more interested in quitting.

Health professionals can play a key role in educating individual smokers and community groups about the hazards of smoking (Ockene, 1987), but they should be practitioners in emergency rooms and public health clinics as well as regular physicians so that the low-SES groups with the highest proportion of smokers are reached. Medical-based programs should be offered in the hospital and public health clinics and emergency rooms where black smokers receive a disproportionate amount of their medical care (Orleans et al., 1989b). The National Medical Association could play a critical role by training its members to offer brief counseling and self-help materials as part of routine medical care (e.g., Glynn and Manley, 1989).

Influential members of important nonmedical organizations also should be involved to raise consciousness about smoking as a health and social issue in black communities. The key spokespersons in Philadelphia's successful campaign against Uptown cigarettes included health professionals, public health officials, political leaders, and clergy from the black community (Robinson et al., 1990).

Communications aimed at black children and adolescents should include peer education. Recent focus groups indicate that information about smoking risks for blacks may be more credible coming from black than from white sources, and that information about other quitting benefits may be most convincing when the sources are "everyday" people instead of celebrities (James et al., 1990). Communications aimed at families and social networks have the potential to increase social support for quitting smoking and to mobilize efforts to curtail cigarette use among black children and adolescents. Widespread community concern to protect black children from a lifetime of nicotine addiction was a major tactic in the successful grassroots campaign against Uptown cigarettes in Philadelphia (Robinson et al., 1990). Interventions that target youth may reach both young people and their families; for instance, the making of a rap video, "Stop Before You Drop," by the Richmond Quits Smoking Project in Richmond, California, was a mobilization tactic that reached families as well as over 300 young people involved in the production at various levels.

Many effective health education campaigns combine formal and informal interpersonal communications, such as personal medical advice and social support from one's primary social group (McDill, 1975; Warnecke et al., 1978). This may be especially true within the black community because of its strong self-help tradition. Recruiting and training volunteers from churches, neighborhood councils, and community organizations to talk with family members, friends, coworkers, and neighbors about smoking was one strategy used by the Richmond project to extend formal programming to informal social networks (Hunkeler et al., 1990).

Community-based motivation or education campaigns should employ black-focused media (e.g., newspapers, magazines, and radio) to the greatest extent possible. The need to reach blacks with the lowest SES and educational levels requires that print materials be suitable for low-literacy populations (Doak et al., 1987) and that alternative audiovisual media also be available.

Videotaped or televised quit-smoking programs are useful complements to print materials, especially to reach low-literacy groups. Minimal counseling might be provided to smokers using self-help materials by means of toll-free telephone quitlines, like the nationwide Cancer Information Service (1-800-4-CANCER), although few black smokers may avail themselves of this service.

Briefly trained lay leaders (Lando et al., 1990) can provide quit-smoking assistance through organizations and institutions already established in the black community. The project in Richmond, California, recruited volunteers through churches, neighborhood councils, and community organizations to encourage, support, and assist quitters. Schoenbach and colleagues (1988) trained life insurance agents to deliver self-help quitting guides to interested policyholders nationwide.

Interventions aimed at groups and organizations, not just individuals, are needed. Self-help programs, workshops, and clinics can be offered in churches, medical settings, schools, workplaces, and community organizations. The Richmond project distributed stop-smoking materials in more than 100 community sites, including restaurants, barber shops, youth organizations, recreational centers, senior centers, grocery stores, churches, the public library, and unemployment offices (Hunkeler et al., 1990).

Voluntary health organizations, particularly the American Cancer Society and the American Lung Association, are the major providers of self-help materials and quit-smoking clinics in the United States (US DHHS, 1989). Their multiracial quitting guides are designed for wide appeal to blacks and other

minorities and are written at reading levels suitable for low-literacy smokers (American Cancer Society, 1988; Strecher and Rimer, 1987). The community and worksite-based clinics of both organizations achieved similar, relatively modest outcomes (Lando et al., 1990). Both programs can be led by facilitators recruited and trained from the target community.

An issue at present is the role of generic stop-smoking materials versus black-focused materials. Both have their place. The experience of the Richmond project was that blacks were very receptive to both black-focused motivational materials and black-focused quit-smoking guides. Examples of black-focused stop-smoking literature include *A Guide to Quitting Smoking*, created by the Richmond project, and North Carolina Mutual Insurance Company's *Quit for Life* guide, designed as a companion to the multiracial guide, *Freedom from Smoking for You and Your Family*, from the American Lung Association (Strecher and Rimer, 1987).

It is noteworthy that offers of standard counseling, groups, and self-help materials will reach only a small group of black smokers. However, the experience of the Richmond project was that, while the program had to offer these services to gain credibility and to accommodate the few who used them, most black smokers who were interested in cessation needed more innovative approaches to quitting.

#### Content of Messages

Messages about smoking for black Americans should contain clear information about the health consequences of smoking, the health benefits and other potential gains from quitting smoking, suggestions for how to quit smoking, and information to combat the cigarette companies' message that smoking is glamorous. Information about the health risks of secondhand smoke exposure should be included to exploit the altruistic quitting motives commonly cited by black ex-smokers (Orleans et al., 1989a).

Because health is the primary motivation for quitting among black smokers, as among all U.S. smokers (Orleans et al., 1989a) and because blacks do not receive messages about the health risks of smoking as often as do whites (US DHHS, 1987), black-focused antismoking campaigns should clearly state the health risks and the benefits of not smoking. Messages should emphasize the fact that while quitting smoking is not easy, it can be done, and that there are individuals interested in helping others quit. Other benefits, not strictly health-related, such as freedom from addiction and inconvenience, saving money, greater self-esteem, and more social acceptability, should be stressed. Reassurance about overcoming common quitting barriers, for example, concerns about weight gain and the loss of smoking as an all-purpose coping tactic, also is important.

The smoking issue should be framed in ways relevant to the concerns of blacks, particularly with regard to family life, for instance, emphasizing the economic burden of smoking-related illness for black families and the hazardous effects of secondhand smoke on children (Hunkeler et al., 1990; James et al., 1990). Family themes like these are emphasized in the American Lung Association's new motivational brochure (1990) developed specifically for black smokers. These messages are similar to those meant for all other racial or ethnic groups, but there is a difference in tone and emphasis. Many blacks are already well aware of the problems they face (unemployment, higher mortality rates, drug abuse, etc.), including smoking. What is needed is more information on how blacks can combat smoking personally, in their families, and in the wider community by organizing to decrease the advertising of cigarettes (Hunkeler et al., 1990).

Counteradvertising has become an essential antismoking strategy in minority communities. Its goals are to expose the tactics used by the tobacco industry to recruit new smokers, especially minority women, children, and adolescents. Counteradvertising can deglamorize smoking through images and slogans that mock the themes of power, attractiveness, escape, popularity, and pleasure that are used now to promote cigarettes (Blum, 1989; Tuckson, 1989). One of the successful tactics in the campaign against the new Uptown cigarettes was to expose the tobacco industry strategy of marketing more highly addictive, high-nicotine and high-menthol cigarettes to black smokers (Robinson et al., 1990).

Counteradvertising strategies can involve everyone, non-smokers and smokers alike. Recently, the City Council of the predominantly black city of Richmond, California, in a preliminary vote, passed an ordinance that prohibits billboard advertising of alcohol and cigarettes within 500 feet of each school. Thus, whole communities can be mobilized against smoking.

The community-based project in Richmond portrayed smoking as "unhip," "uncool," and socially undesirable behavior (Hunkeler et al., 1990). Counteradvertising can also include (1) political action and legislation to regulate the billboard cigarette advertising that is two to three times more prevalent in black than in white communities; (2) strategies to reduce point-of-purchase advertising and curtail minors' access to tobacco products in community retail establishments and to prohibit the distribution of free samples of cigarettes; (3) stopping patronage of events sponsored by tobacco companies; and (4) the refusal of philanthropy from tobacco companies (Tuckson, 1989).

### Smoking Among Hispanics Magnitude of the Problem

The proportion of current smokers among Hispanic men varies from 31 percent to 41 percent, and among Hispanic women from 21 percent to 33 percent, in national and regional surveys (Escobedo and Remington, 1989; Escobedo et al., 1990; Marcus and Crane, 1985). Rates for Hispanic men are similar to or greater than those for white men, but a substantially lower proportion of Hispanic women than white women are smokers. Smoking rates for the three major Hispanic subgroups, Mexican Americans, Cuban Americans, and Puerto Ricans, were compared in the Hispanic Health and Nutrition Examination Survey (HHANES) conducted between 1982 and 1984 (Escobedo and Remington, 1989). Similar gender differences were observed among Mexican Americans and Cuban Americans, but the gap was much less striking among Puerto Ricans. Puerto Rican women report smoking at a much higher rate than either of the other Hispanic subgroups examined as part of HHANES. In addition, birth cohort analyses based on HHANES data estimated that, although the prevalence of smoking appears to be decreasing among Hispanic men, smoking rates actually increased among successive cohorts of Hispanic women (Escobedo and Remington, 1989).

### Barriers to Smoking Cessation

Acculturation to the U.S. mainstream is a complex, multidimensional phenomenon that has an important but poorly understood role in many health-related behaviors. In a telephone survey of smoking behavior, completed with 1,669 Hispanic residents of San Francisco in 1986-1987 (Marin et al., 1989b), smoking rates were higher for the more acculturated Hispanic women but lower for the more acculturated men. These data suggest that smoking behavior among Hispanics becomes more like that of whites with increasing levels of acculturation and, as a consequence, smoking may become an increasingly serious problem for Hispanics as they merge with mainstream U.S. society.

A consistent finding in surveys (Marcus and Crane, 1985; Marin et al., 1989b) has been that Mexican-American smokers report smoking fewer cigarettes per day than the average reported by white or black smokers. Although a lower proportion of highly acculturated men smoke, they report a greater number of cigarettes per day than less acculturated men. Among women, a high proportion smoke and report smoking more cigarettes as acculturation increases. Among a sample of 547 Mexican-American smokers participating in HHANES, comparison of self-reported smoking behavior with levels of serum cotinine (a specific metabolite of nicotine) showed that approximately 20 percent of men and 24 percent of women reported smoking fewer than 10 cigarettes per day, and that estimated underreporting of cigarette consumption ranged from 2 to 17 cigarettes per day (Pérez-Stable et al., 1990). These



observations have important implications for cessation strategies, because light smokers are much more likely to successfully quit smoking on their own with appropriate motivational messages and self-help methods.

Unemployment, little education, and little or no awareness of cessation services also contribute to the barriers that Hispanics face in attempting to quit smoking. Less educated persons are more likely to smoke and less likely to quit, and Hispanics have the fewest average years of education of any ethnic group in the United States. Up to 50 percent of adolescents from all subgroups do not graduate from high school. In addition, many Hispanic immigrants have little formal education and at least 25 percent speak little or no English; thus, smoking prevention and cessation services are less accessible to them.

With regard to barriers at the individual level, cigarette smoking remains a socially acceptable behavior among Hispanics. Few Hispanics question whether it is permissible to smoke at a private home and many consider offering a cigarette a polite gesture (Marin et al., 1989a). Smokers attempting to quit may confront situations in which they must politely refuse a cigarette in a culturally appropriate manner. Smoking among Hispanic men is perceived also as part of the machismo culture. The tobacco industry has exploited these cultural traits in advertising campaigns aimed at Spanish-speaking people.

Providing services to Hispanic Americans, whether at the individual level, in a clinical setting, or for an entire community, requires a working knowledge of social and cultural issues. Financial access to health care, immigrant documentation status, reasons for emigration from Latin America, and SES in the United States are all essential issues that persons planning to work with Hispanics must recognize. Because the proportion of Hispanic health professionals in the United States does not come close to the proportion of Hispanics in the population, non-Hispanics will be providing a substantial number of services; awareness of specific cultural issues may help to reduce the known barriers.

On average, Hispanics are younger, less educated, and have an SES level intermediate between that of whites and blacks who are not Hispanic. More than 80 percent of Hispanics reside in urban areas and nearly 90 percent live in New York, Florida, Illinois, New Jersey, and five Southwestern states (California, Texas, New Mexico, Arizona, and Colorado). Although Hispanics are a racially diverse group, with each country of origin imparting unique characteristics, there are more similarities than differences among Hispanic subgroups in this country. For example, Spanish is the language preferred

for use at home by 60 percent of Hispanic adults, which creates a bonding among subgroups (Pérez-Stable, 1987).

To promote smoking cessation and prevent smoking initiation among Hispanics, interventions must incorporate culturally appropriate information about why and how to quit smoking. Standard use of broadcast Spanish that avoids regional idioms should be used in all of the media components. Hispanic physical types that represent the national groups in the area also should be used as models and communicators.

The Spanish-language media can play an important role in promoting nonsmoking. Television and radio public service announcements can be produced at low cost and aired on the major Spanish-language stations in a specific area. These public service announcements can include culturally appropriate messages about smoking and how to quit, with community leaders talking about the disadvantages of smoking and former smokers talking about why they quit and what benefits they have gained. Less acculturated Hispanics are more likely to listen to radio, and discussions of smoking and health by Hispanic experts on locally popular radio talk shows can be an effective way of reaching Hispanics. The call-in talk show format allows for listener participation, lively discussions, and testimonials by former smokers.

There are Spanish-language newspapers publishing weekly or monthly in most U.S. areas that have a significant Hispanic population. In some urban areas (e.g., Los Angeles, Miami, and New York), a prominent daily newspaper is widely read by Hispanics, but in many areas the absence of a daily newspaper in Spanish means that Hispanics read English language newspapers (Alcalay et al., 1987-1988). Newspapers and magazines are susceptible to influence by the tobacco industry's advertising dollars and thus may be less amenable than radio and television to promoting nonsmoking; however, other printed media in Spanish may have an important role in promoting smoking cessation. For example, posters showing a family quitting cigarettes, flyers with motivational messages, pamphlets with information on how to help a smoker quit, and billboards promoting the no-smoking message can all be part of a Hispanic-focused program of smoking control. The messages in printed media should be aimed at nonsmoking family members as well as smokers, in order to make the most of the powerful characteristic of familial regard among Hispanics.

Hispanics tend to have a collective loyalty to the extended family that ranks higher than individual needs (*familialismo*), and this quality may be useful in an effort to change smoking behavior. For example, motivating fathers or mothers to quit

#### Content of Messages

#### Channels for Reaching Hispanics

smoking in order to prevent their children's smoking and to decrease the likelihood of harm to their children is an appropriate and effective strategy to use among Hispanics. The extended family network remains much more intact among Hispanics in general when compared with whites, even after several generations have passed since immigration (Sabogal et al., 1987). The family network can be used also to persuade smokers to quit. An example of a vignette related to real-life issues in the community is a television public service announcement showing a delighted Hispanic mother reading a letter from her son, who writes that he has quit smoking on Mother's Day because of his children.

Hispanic people often will establish relationships with health professionals and other authority figures out of a paternalistic dependence. Because of this cultural trait of respect for authority figures, physicians and other health professionals in a clinical setting may be especially effective in counseling Hispanic smokers about quitting. Physicians need to implement a more authoritative style, use standard counseling techniques to promote cessation, and order adjunctive pharmacologic methods as needed. Authoritative experts have enhanced credibility in promoting nonsmoking among Hispanics both at an individual encounter and through a public health campaign. This relationship, however, depends on maintenance of respect for the individual regardless of social standing, and it can disintegrate if non-Hispanics are not aware of these cultural scripts. For example, Triandis and colleagues (1984) described the cultural script of *simpatía* that differentiates Hispanics from whites; this script means that Hispanics are more likely than whites to expect a high frequency of positive social interaction and a low frequency of neutral or negative social interactions. Inattention to the presence of this script may lead to misunderstandings when Hispanics and people of other cultures interact in any social setting.

Although Hispanics report having less awareness than that of other groups about where to obtain information on smoking cessation services, they state also that they need less help in quitting and feel more capable of quitting on their own. In fact, the most frequently cited method by Hispanic smokers in helping them to quit is *voluntad propia*, or willpower. Promotion of willpower with self-help methods, such as the *Guía para Dejar de Fumar* (Sabogal et al., 1988), is an effective strategy to use among Hispanic smokers.

Compared to white smokers, Hispanics perceive their smoking to be less dependent on situational cues and more dependent on social cues. The importance of cigarette smoking with a group of friends or at a social gathering is greater for Hispanics than for whites. Thus, antismoking messages must

include culturally appropriate ways to resist social pressures to smoke. Hispanics were more concerned also about the effects of smoking on interpersonal relationships and about smoking making their clothes and their breath smell bad. This also should be incorporated into antismoking messages. Finally, Hispanics report a greater concern about the effects of smoking on their health and the health of their children. Thus, graphic presentations of the adverse health effects of smoking on smokers and their loved ones may be effective if presented within a context that offers ways to quit smoking.

Helping smokers quit with the more traditional cessation group approach has not been widely accepted by Hispanic smokers, even when offered free of charge at convenient hours and locations. Use of a series of Spanish-language audiotapes that include professionally enacted vignettes to illustrate the principles of relapse prevention, relaxation techniques, and assertiveness when coping with social temptations to smoke may be widely applicable through radio programs. One approach to complement the standard group cessation is to offer counseling sessions for smokers over the telephone. It has the advantage of being time-efficient, allows for a much wider dissemination of quitting techniques, and should be cost-effective.

## CONCLUSIONS

- In the limited number of settings where interactions between the multiple components of a smoking control program have been examined, there appears to be a synergistic effect.
- Interaction between the multiple components of the environmental system and the multiple message channels that compose a comprehensive strategy for smoking control is expected, in light of current social behavior theory, and the anticipated interaction has been incorporated into most recent comprehensive, community-based, smoking control approaches, such as COMMIT and ASSIST.
- The targeting of women by tobacco advertising has been associated with a dramatic rise in the number of women who smoke and who develop smoking-related diseases.
- Approaches toward blacks include programs to counter targeted advertising within black neighborhoods, increasing the priority and resources available for smoking control within black groups, and encouraging the dissemination of programs and materials developed for use in the black community.
- The recognition of the importance of acculturation and Hispanic social and cultural issues is essential in implementing smoking control programs in Hispanic communities. Approaches that emphasize family impact may be particularly useful.

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# MY STORY

One day a friend of mine wanted to steal. I knew it was wrong and I had a tough decision to make. I thought to myself: If I don't do it, he'll probably call me scary or not be friends with me. If I do it, he'll probably call me cool and brave, but I thought and did the right thing. I chose to not steal and to spend time looking for a better friend.

Stephen Rogas  
6th Grade  
New Orleans, LA

One day a friend of mine wanted me to smoke. I knew it was wrong and I had a tough decision to make. I thought it over and said, "No." I knew I would get in trouble. Though this girl was my neighbor and friend, I still said "No." I have always said, "I would never smoke for anyone." Also, this girl was young, about 8 years old. She did it, but I didn't because I knew it was wrong.

Monica Martinez  
6th Grade  
New Orleans, LA

51604 6023

# MOVIES MUSIC TV

Is Jonathan Brandis giving up acting? We don't think so, but he does love to write and has just submitted a synopsis for an episode of "seaQuestDSV."

Look for **Eddie Farsang** in the upcoming film "Brainscan," where he is trapped in a virtual reality nightmare and doesn't know whether he is experiencing fantasy or reality.

On "Melrose Place," **Beyonce Zumiga** spends a lot of time snapping photos. Off the set, she's more likely to be found revving up her Harley - usually for a good cause like the celebrity motorcycle race for Muscular Dystrophy.

**Dean Cain**, the "man of steel" on "Lois & Clark: The New Adventures of Superman," played the guy Shannen Doherty fell for in France last season on "90210."

Did you know that the drawings you see on the refrigerator on "Roseanne" are actually created by Roseanne's nieces?

Be sure to check out the summer flick "Endless Summer II," which follows pro surfers Robert "Hugoboss" Weaver and Pat O'Connell around the world as they search for the perfect wave.

**Christina Ricci's** favorite group is the Red Hot Chili Peppers and "90210" is her favorite show.

Although **Mariah Carey** turned down a role in the movie version of "Evita," she'd never turn down the chance to act in a remake of "My Fair Lady." She's just waiting for the offer.

Who knew that **Joey Lawrence's** first album wasn't "Joey Lawrence," but actually an album for the classic kid show "Romper Room"?

SPRING, 1994 ISSUE 4

RIGHT  
DECISIONS  
RIGHT  
NOW

WHAT'S  
INSIDE

AN  
INTERVIEW  
WITH  
MELISSA  
JOAN  
HART

MY STORY

GIVE ME  
MORE/  
ENOUGH  
ALREADY

MOVIES  
MUSIC  
TV

EXHIBIT

Verter 28  
3-22-97

.....  
**Baby Ts**  
**Virtual Reality**  
**Cookie Dough**  
**Dan Jansen**  
**Speed Racer**  
**Sega Sports**  
**Planet**  
**Hollywood**  
**Fresh Prince**  
**of Bel Air**

**GIVE ME MORE**  
  
**ENOUGH ALREADY**

**Chokers**  
**Hassles**  
**Professional**  
**Wrestlers**  
**Disco**  
**People With**  
**Attitudes**  
**Power Rangers**  
**Olympic Figure**  
**Skating**

51604 6024

# MELISSA JOAN HART



She's smart. She's sassy. She's hip...She's 18-year-old Melissa Joan Hart, dispenser of wit and wisdom to millions of fans on Nickelodeon's top-rated series, "Clarissa Explains It All." As the outspoken and undeniably cool Clarissa Darling, Melissa captures the essence of teenage life like no one else on television. "Clarissa's not the average cardboard-cutout Barbie Doll character," explains Melissa of her outspoken alter-ego. "She dresses differently, her room is weird, she's kind of alternative. That's what I think makes her so appealing." Melissa credits the show's unique blend of hipness, humor and honesty for its tremendous success. "It's not like a stupid sitcom, where they end up with a lesson at the end," she says. "It's more like you end up with whatever's fun and cool."

Since her acting debut at age four in a national commercial, she has starred in some made-for-tv movies and appeared in several episodes of "Saturday Night Live" and the soap opera "Another World." It was "Clarissa Explains It All," however, that really put her in the spotlight. In addition to the weekly series on Nickelodeon, she released her first video, "Clarissa Explains: Dating," a guide to teen relationships as viewed through the eyes of her popular character, and wrote the book "Clarissa's All-in-One Perfect Complete Book of Everything Important (Until I Change My Mind!)." She is also working on a new series for CBS called "Clarissa" and, most recently, began an advice column in Teen Beat magazine called "Melissa Explains It All."

One drawback to "Clarissa" is that the show tapes at Nickelodeon Studios in Orlando, which keeps Melissa away from her family and friends. This really makes her grow up quickly, as she does her own grocery shopping, handles all of her own finances and meets with a tutor on set so she can graduate from high school this year.

Back home in New York, she loves hanging out with her friends, going to the movies or a Broadway play. What a night out doesn't include is drinking and doing drugs. In fact, Melissa says she has never been drunk and never even touched drugs. She strongly believes in the "Just Say No" attitude. "If you try something once, you might get stuck on it and you don't know how you're going to act," Melissa explains. "I can have fun without drinking." This is why she avoids the bars and club scene. Besides, Melissa adds, "Smoking is the worst. I hate being around smokers." Melissa explains, "I can have fun without giving in to peer pressure. My friends totally respect my decisions. If they don't, I'd find other people to hang out with."

What's Melissa's idea of a perfect evening? Well, she loves hanging out at a friend's house, gossiping, eating cookie dough and watching "Beverly Hills 90210." If you do that, and follow Melissa's advice, you, too, can make the "right decisions, right now."

To contact Melissa Joan Hart, writer:

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 Rogers & Cowan  
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 Los Angeles, CA 90067

# My Story

Soon after our 6th grade graduation, one girl named Robin\* threw a party. Her parents smoked, so there were packs scattered around the house. At the party, Steve\* and Gary\* (two of the "cool kids") picked up a pack.

The next night, we had another party in a very wooded or rural area, so it was easy to sneak away. Steve and Gary brought the pack and chose 3 people to go with them into the woods. The 3 people were me, David\* (my best friend) and Dana\*, another "cool kid". At first I didn't know why they wanted my friends and I, but I could smell their breaths and soon figured it out. Since my sister smoked, I am familiar with the smell. We sat down and started to talk. I thought I was crazy thinking that they were going to give us cigarettes. But then Gary brought one out. I was relieved to see that he only brought one out. I thought it was for him only. Then he passed it to Steve who took a couple of puffs. Gary then gave it to Dana. I didn't think that Dana would do it because she was trembling, but somehow her hands managed to put it in her mouth. I began thinking I was next! Dana took one puff, coughed it out and just got up and left angry and mad at herself and Steve and Gary. Slowly but surely, it was my turn. The same sentence was repeating over and over in my head, "Should I do it and be cool, or should I not and be cool at the same time?" They handed it to me and I threw it on the ground and stomped it out. I looked into their eyes, felt sorry for them and left. I was very pleased to hear that right after I left, David followed.



It turns out that the only "cool kids" were me, David and Dana. Even though it took me a long time to realize that, it was worth the wait. When I think back on it now, I am glad that I made that decision. I am proud of myself and my two friends. Also, I am happy that on that night I found out who my friends really were.

**Jonathan Kelley**  
7th Grade  
Sherman Oaks, California

\*Names have been changed



## MOVIES / MUSIC / TV

Did you know that **"The Flintstones"** cartoon series is going to be a live-action movie soon? Other TV shows heading for the big screen are: **"The Brady Bunch," "Flipper," "Star Trek: The Next Generation," "The Beverly Hillsbillies"** and **"Car 54, Where Are You?"**...

The hottest new game being played all over the world is **"Nightmare."** This interactive video board game, invented in Australia, has players on the edge of their seats competing against each other and the horrific host, **"The Gatekeeper,"** who appears on your television screen.

When **Macaulay Culkin** is not working on a film, he attends New York's Professional Children's School. **Christian Slater** and **Sarah Jessica Parker** also went there...

**Pearl Jam, Nirvana** and **Garth Brooks** are some of the artists who will be contributing to a tribute album for the group **RUSS**. All of the money raised from the album, which features artists doing their versions of classic **RUSS** songs, will go to charity...

Did you know that **Jeremy Jordan** was discovered at Demon Dogs hot dog stand in Chicago where he was in line for a dog, fries and a Coke?...

Look for **Jason Priestly** to be directing more episodes of **"90210"** this season. He directed last spring's **"Senior Ditch Day"** episode...

The R&B group **Sisters With Voices, a.k.a. SWV (Cherry Gamble, Leanne Lyons and Tamara Johnson)** have been singing together since junior high. The group was inspired by **New Edition**...

Be on the lookout for **"The Next Karate Kid"** starring **Hillary Swank**. That's right, a girl has taken over as the title role. Hillary is currently shooting the film in Boston and Washington, DC.

**Double Dragon**, one of the most popular arcade and video games of all time, will soon be a major motion picture. The film, due out in the spring, stars **Robert Patrick, Mark Dacascos, Scott Wolf** and **Alyssa Milano**...

5209 80915

EXHIBIT

Verner 30

3-22-97

Kellie Martin on Peer Pressure  
My Story  
What's Hot What's Not  
Movies/Music/TV

RIGHT  
DECISIONS  
RIGHT  
NOW

IN THE MIDDLE OF MY EIGHTH GRADE YEAR, I CAN REMEMBER ONE SPECIFIC TIME WHEN PEER PRESSURE PLAYED A BIG PART IN MY LIFE.

IT WAS A HALF DAY AT SCHOOL. AFTER EARLY DISMISSAL, MOST OF THE KIDS WALKED DOWN TO THE DUCHESSES TO GRAB SOMETHING TO EAT. IN OUR SCHOOL, THERE WERE ALWAYS DIFFERENT CROWDS: THE "SKATERS" (SMOKERS AND DRINKERS), THE "PREPS" AND THE COMPLETE RECLUSIVES. THE "SKATERS" ALWAYS WALKED DOWN TO THE CASCADES AFTER THE DUCHESSES. THAT YEAR I PROBABLY WOULD HAVE CONSIDERED MYSELF A "PREP"/"SKATER" BECAUSE I DID HAVE FRIENDS THAT WERE "SKATERS."

## My Story

I, FRIENDS AND I DECIDED TO GO FOR A SWIM AT THE CASCADES.

GUYS WHO ELSE WAS THERE? THE SKATERS. ONE BOY IN PARTICULAR ALWAYS PICKED ON THE PREPS. HE NEVER REALLY BOTHERED ME THOUGH. HE WAS SMOKING AND ASKED ME IF I WANTED A DRUG. I KNEW THAT SMOKING WAS WRONG AND THAT IT COULD GET YOU REALLY SICK. BUT, I THOUGHT THAT IF I DID NOT SMORE, ALL OF MY "SKATER" FRIENDS WOULD NOT WANT TO SPEAK TO ME BECAUSE THEY WOULD THINK THAT I WAS A COMPLETE LOSER. AFTER JOINING THE CORSETTE, THREE TIMES, I FIGURED THAT IF THEY THOUGHT THAT I WAS A LOSER FOR NOT SMOKING, THEN THEY WOULDN'T REALLY MY FRIENDS. I TOLD THE KIDS THAT I DID NOT SMORE AND THAT I DID NOT WANT THE CORSETTE. THEY LAID OFF AND DID NOT BOTHER ME OR MY FRIENDS FOR THE REST OF THE DAY. NOT ONLY DID THAT MAKE ME FEEL GOOD, BUT MY FRIENDS ALSO RESPECTED MY DECISION.

— SUMMA INDEPENDENT, 8TH GRADE  
FAIRFIELD, CT

# MOVIES

The relentlessly wholesome, perky, clean-cut and wide-eyed family viewing clashing, loud satire is back in the upcoming **BRADY BUNCH** film. The film is set in the 90's but the Bradys themselves are unchanged.

Word is that the dinosaurs will be back in summer 1997 with a sequel to **JURASSIC PARK**. Although Steven Spielberg is not big on making sequels, JURASSIC'S \$900 million success makes it an exception. Yep, a third Deck movie - **D-3** is being planned as well as two more Walt Disney is also considering turning the Mickey Mouse TV series.

Chris O'Donnell just scored the role of a lifetime in **BAUTMAN III**. The competition was fierce for the role of the "What's Eating Gilbert Grape?" and Jeremy Renner was the favorite.

**MTV - ONLINE**. MTV has teamed up with the Internet to launch MTV "O.J." (online jockey) will travel around the country and report hand on all the goings-ons.

# MUSIC

We can't wait till January 1 when "The Roots" release their first album of Rhythmic music. The all new tunes. So roll the credits...

Shaquille O'Neal, the 7'1" wonder of the NBA, is heading ahead with a follow-up album to his much-awaited, **"SNAQ FOR DA RETN"**.

Jocely Lawrence, who plays Joey Russo on the TV season with a career in beach volleyball, is releasing his second album (expected '94 release) college at USC.

**"SUPERHERO MAN SAYS"** Matthew Lawrence's own new sci-fi action series is the talk of the fall. Matt is really excited about the character Sam Collins is a rock and roller on the show.

**RIGHT DECISIONS RIGHT NOW**

EXHIBIT

Version 31

3-22-97

WHAT'S INSIDE

Give Me Your  
Enough Love

Interview with  
Santitas

By Sam

Movies: Music TV

51604 6026

To Contact Staff: Keenan, write:

## DECISION

to be friends with you.

110-1105 SEXUAL ABUSE AND NEGLECT BY BAPTIST  
- 110-1106 NON-CHURCHING AND OTHER SPIRITUAL AND BAPTIST  
110-1107 110-1108 110-1109 110-1110 110-1111 110-1112 110-1113 110-1114 110-1115 110-1116 110-1117 110-1118 110-1119 110-1120 110-1121 110-1122 110-1123 110-1124 110-1125 110-1126 110-1127 110-1128 110-1129 110-1130 110-1131 110-1132 110-1133 110-1134 110-1135 110-1136 110-1137 110-1138 110-1139 110-1140 110-1141 110-1142 110-1143 110-1144 110-1145 110-1146 110-1147 110-1148 110-1149 110-1150 110-1151 110-1152 110-1153 110-1154 110-1155 110-1156 110-1157 110-1158 110-1159 110-1160 110-1161 110-1162 110-1163 110-1164 110-1165 110-1166 110-1167 110-1168 110-1169 110-1170 110-1171 110-1172 110-1173 110-1174 110-1175 110-1176 110-1177 110-1178 110-1179 110-1180 110-1181 110-1182 110-1183 110-1184 110-1185 110-1186 110-1187 110-1188 110-1189 110-1190 110-1191 110-1192 110-1193 110-1194 110-1195 110-1196 110-1197 110-1198 110-1199 110-1200 110-1201 110-1202 110-1203 110-1204 110-1205 110-1206 110-1207 110-1208 110-1209 110-1210 110-1211 110-1212 110-1213 110-1214 110-1215 110-1216 110-1217 110-1218 110-1219 110-1220 110-1221 110-1222 110-1223 110-1224 110-1225 110-1226 110-1227 110-1228 110-1229 110-1230 110-1231 110-1232 110-1233 110-1234 110-1235 110-1236 110-1237 110-1238 110-1239 110-1240 110-1241 110-1242 110-1243 110-1244 110-1245 110-1246 110-1247 110-1248 110-1249 110-1250 110-1251 110-1252 110-1253 110-1254 110-1255 110-1256 110-1257 110-1258 110-1259 110-1260 110-1261 110-1262 110-1263 110-1264 110-1265 110-1266 110-1267 110-1268 110-1269 110-1270 110-1271 110-1272 110-1273 110-1274 110-1275 110-1276 110-1277 110-1278 110-1279 110-1280 110-1281 110-1282 110-1283 110-1284 110-1285 110-1286 110-1287 110-1288 110-1289 110-1290 110-1291 110-1292 110-1293 110-1294 110-1295 110-1296 110-1297 110-1298 110-1299 110-1300 110-1301 110-1302 110-1303 110-1304 110-1305 110-1306 110-1307 110-1308 110-1309 110-1310 110-1311 110-1312 110-1313 110-1314 110-1315 110-1316 110-1317 110-1318 110-1319 110-1320 110-1321 110-1322 110-1323 110-1324 110-1325 110-1326 110-1327 110-1328 110-1329 110-1330 110-1331 110-1332 110-1333 110-1334 110-1335 110-1336 110-1337 110-1338 110-1339 110-1340 110-1341 110-1342 110-1343 110-1344 110-1345 110-1346 110-1347 110-1348 110-1349 110-1350 110-1351 110-1352 110-1353 110-1354 110-1355 110-1356 110-1357 110-1358 110-1359 110-1360 110-1361 110-1362 110-1363 110-1364 110-1365 110-1366 110-1367 110-1368 110-1369 110-1370 110-1371 110-1372 110-1373 110-1374 110-1375 110-1376 110-1377 110-1378 110-1379 110-1380 110-1381 110-1382 110-1383 110-1384 110-1385 110-1386 110-1387 110-1388 110-1389 110-1390 110-1391 110-1392 110-1393 110-1394 110-1395 110-1396 110-1397 110-1398 110-1399 110-1400 110-1401 110-1402 110-1403 110-1404 110-1405 110-1406 110-1407 110-1408 110-1409 110-1410 110-1411 110-1412 110-1413 110-1414 110-1415 110-1416 110-1417 110-1418 110-1419 110-1420 110-1421 110-1422 110-1423 110-1424 110-1425 110-1426 110-1427 110-1428 110-1429 110-1430 110-1431 110-1432 110-1433 110-1434 110-1435 110-1436 110-1437 110-1438 110-1439 110-1440 110-1441 110-1442 110-1443 110-1444 110-1445 110-1446 110-1447 110-1448 110-1449 110-1450 110-1451 110-1452 110-1453 110-1454 110-1455 110-1456 110-1457 110-1458 110-1459 110-1460 110-1461 110-1462 110-1463 110-1464 110-1465 110-1466 110-1467 110-1468 110-1469 110-1470 110-1471 110-1472 110-1473 110-1474 110-1475 110-1476 110-1477 110-1478 110-1479 110-1480 110-1481 110-1482 110-1483 110-1484 110-1485 110-1486 110-1487 110-1488 110-1489 110-1490 110-1491 110-1492 110-1493 110-1494 110-1495 110-1496 110-1497 110-1498 110-1499 110-1500 110-1501 110-1502 110-1503 110-1504 110-1505 110-1506 110-1507 110-1508 110-1509 110-1510 110-1511 110-1512 110-1513 110-1514 110-1515 110-1516 110-1517 110-1518 110-1519 110-1520 110-1521 110-1522 110-1523 110-1524 110-1525 110-1526 110-1527 110-1528 110-1529 110-1530 110-1531 110-1532 110-1533 110-1534 110-1535 110-1536 110-1537 110-1538 110-1539 110-1540 110-1541 110-1542 110-1543 110-1544 110-1545 110-1546 110-1547 110-1548 110-1549 110-1550 110-1551 110-1552 110-1553 110-1554 110-1555 110-

your individuality," says Stach. "Peer pressure also was a problem in high school. Peer pressure often decays in college. It's a direct confrontation. I say it's subtle ways than a direct confrontation. She recalls attending a party where a lot of people were smoking. No one directly pressured her, but the atmosphere made the right decision for her. For her, Stach made the right decision for her and made others in the room also feel good about it. She makes their own decisions. Stach maintains.

"Everyone is always craving to be liked and to be liked by the right people. So the most important thing is to help them."

hat takes most actresses a lifetime to accomplish, 9-year-old Staci Keenan has achieved in a relatively

short time. You will remember that these "New Englanders" were "strongly opposed to the abolition of slavery."

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MAY 21 1961

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PEOPLE WHO WHINE  
TEMPORARY TATTOOS  
BELL BOTTOMS  
PREJUDICE  
THE BASEBALL STRIKE  
NINJA TURTLES  
GUMMY BEARS  
FRIENDSHIP BRACELETS

51604 6027

# WINE

Month 2 Mouth  
Poo  
Aapaa  
Chickadee  
The Purple Rainbird  
Song Sparrow  
Blue Jay  
Robin  
Yellow Warbler  
American Goldfinch

**Give me more**



Temporary Tattoos

Take That

Daisy Dukes

Doc Martens

Beavis & Butt-Head

Chokers

American Cars

David Letterman

**HOT  
NOT**

Permanent Tattoos

New Kids on the Block

Baggy Shorts

Birkenstocks

Bart Simpson

Mood Rings

Foreign Cars

Arsenio Hall



## ON PEER PRESSURE

It's hard to think of a better way to end a television series than with an Emmy nomination. And

Kellie Martin has done just

that. After four seasons, Martin received a nomination for her role as Becca Thatcher on the critically acclaimed series "Life Goes On."

Since "Life Goes On" wrapped, Kellie has been busy with other projects including a guest starring role on Steven Spielberg's new adventure series "seaQuest DSV," which airs this fall on NBC. She also co-stars with Dennis Weaver in the upcoming ABC Afterschool Special, "Montana Crossing," about family and relationships. Come next fall, Kellie will be off to Yale University where she hopes to major in literature. Three thousand miles from Hollywood won't deter Kellie from acting. Yale's close proximity to New York and its excellent drama department will afford her the opportunity.

Unlike high school, Kellie hopes her college experience will be quite normal. Growing up in front of the camera, Kellie wasn't able to attend high school because of her production schedule. Instead, tutors came on the set daily for private sessions. Last spring, Kellie attended her first prom with her boyfriend in Florida. She had a great time but was surprised by the excessive drinking. Kellie stated, "It's great to have a

# Kellie Martin

good time with your friends, but if you don't remember it, how can it be fun?"

An avid athlete who loves to exercise, Kellie doesn't understand how people can fill their bodies with harmful chemicals. "I love to always be in control of what I do and say, and drinking would prevent me from doing that. Also, I love to exercise and work out and if I smoked, I couldn't do that."

Kellie knows firsthand how hard being a teenager can be. "You are constantly searching for who you are so I understand why teenagers try things. But I think that before you try something that you know is not good for you, you have to stop and say, 'What is this going to do for me?' The likely answer would be 'Nothing.' She adds that if your friends are going to like you more if you smoke or drink, are they really your friends?"

Kellie offers this piece of advice: "Fill your life with things you love and then you don't have to grab on to drinking and smoking. Then, just like Kellie Martin, you, too, can make the 'right' decisions right now."

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5918 Van Nuys Blvd.  
Van Nuys, CA 91401

8209 70915

## MY STORY

My parents have always been close to the Jones\* family. Every once in a while, they'll make plans for our two families to get together.

Since Susan Jones\* is only two years older than I, we were always encouraged to become friends. Ever since our first meeting, I have always looked up at Susan with a mix of admiration and envy, since she seems more mature, and prettier than I.

When I was about ten years old, my family paid one of the nearly routine visits to the Jones' house. On this particular occasion, Becky\*, Susan's best friend was over, too. I immediately respected Becky in the same way as Susan.

Strangely, I viewed them as nearly perfect, even though, now, I understand that they are far from perfection.

From the beginning of the day, they treated me rudely, but when they were forced to offer half-hearted apologies, I quickly accepted. I looked up to them.

Later, we were urged by my mother to go outside. I enjoyed myself in their company; my respect for Becky and Susan had not weakened with their previous behavior.

Then, out of nowhere, Becky displayed a box of cigarettes and a lighter. I was shocked. I had never seen anyone so close to my own age smoke before.

I felt defiant and nervous as I watched Lisa light up. Still, in my eyes, she was older, pretty, and almost perfect, so she could do no wrong.

I was struck with a rush of anger, and nausea when Becky offered me a cigarette. At first, I believed that she would think of me as a lesser person if I declined. Still, I cannot claim that I was torn. I was smart enough to say, "No," and am proud that I was strong enough to resist the pressure from someone who I regarded so highly.

I believe that the decision I made that day has helped me grow as a person. That was the first time peer pressure ever affected me, and it will surely not be the last. The confidence I had in my ability to choose that day has helped me to make more decisions of equal and greater difficulty, and will definitely help me in the future. I am confident in the choice I made, and am positive that I will be able to choose just as well, in the future.

Anna Spinner  
8th grader  
New Haven, CT

\*Names have been changed

## MOVIES / MUSIC / TV

May, 1993

Issue #

EXHIBIT

Volume 29  
3-22-97

RIGHT  
DECISIONS  
RIGHT  
NOW

What's Inside

Macaulay Culkin's world is not his home. It's not

Christopher Lloyd

Whoopi Goldberg, Patrick

Stewart and Leonard Nimoy

Sara Gilbert

Jodie Foster

Marky Mark, Jason Priestley,

Shannen Doherty, Luke Perry

Chris Kelley

Chris Smith

Leonardo DiCaprio's

Kellie

Martin

Boyz II Men's

Elvis Presley

Cindy Crawford

Now, the

Barbra Walters

start

51604 6029

WHAT'S  
HOT  
CABLE  
COUNTRY  
CHARLES  
THE 1970  
GROOVE  
BELL BOND  
HOME  
IMPROVISED  
ROLLERBLADING  
SOCKS THE CAT

NETWORK TV  
HEAVY METAL  
GREED  
THE 1990'S  
PREPPY  
SUSPENDERS  
"MELROSE PLACE"  
SKATEBOARDING  
MILLIE THE DOG

NOT

51604 6030

## Joey Lawrence on Peer Pressure

Joey Lawrence knew since he was four years old that he wanted to pursue a career in show business. "I used to watch a lot of television variety shows, and all I wanted was to be on TV and sing," Lawrence said. When he was five he did both, belting out "Give My Regards to Broadway" on "The Tonight Show Starring Johnny Carson." Lawrence, now 17, has since appeared on the television comedy, "Gimmie a Break" for four seasons, and currently stars in the hit series "Blossom."

With his acting career already in high gear, Lawrence is now concentrating his efforts on his self-titled debut album, *Joey Lawrence* on Impact/MCA Records. A combination of soul and up-tempo dance-pop, the album has already produced the hit single "Nothing My Love Can't Fix." The record company was pleasantly surprised with the single. Joey recalls, laughing, "I did a rap on it, just as an experiment, and they didn't think it was me at first. But they liked it so much we decided to do another called "Justa 'Nother Love Song."

Clearly, Joey has made some excellent career decisions but, growing up in Philadelphia, he has also had to make some important social decisions. "I remember one time I walked into a party where kids were smoking and drinking and I just turned around and left," Joey recalls. Even today, he still feels the same way. "I don't like to hang out with people who smoke or drink." Joey

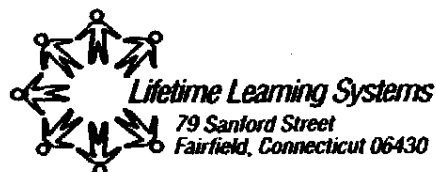


says  
this also  
includes the girls  
he dates.

"We all know that smoking, drinking and doing drugs are not right and there are clear messages on television and in the newspapers that tell us so." But then, Joey added, when you throw in the element of peer pressure, it becomes a much more difficult decision. "You hang out with your friends who are doing it and you say to yourself 'I'm not cool if I don't drink a beer. I'm uncool if I don't smoke.'" Joey's advice is simply, "Be your own person. Don't let others pressure you into making decisions that are wrong or make you feel uncomfortable."

Most importantly, Joey stressed this message — "You should do what you know is right and only do that. If you do, then you're never going to end up regretting something or doing something bad." By following Joey's advice, you too can make the "right decisions, right now."

To contact Joey Lawrence, write:  
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6265 Sunset Boulevard, #100  
Hollywood, California 90028



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# **Free Inside!**

## ***Educational Program To Help Students:***

- ***Identify conflict and how it operates in their lives.***
- ***learn what causes conflicts to get out of hand.***
- ***develop methods for controlling anger and managing conflict situations.***

Vesper 33  
3-22-97



## **Dear Educator:**

Much of what today's students learn about coping with conflict comes from the media and peer groups. For many young people, the lesson learned is that fighting is an acceptable way to deal with conflict and, for some, violent behavior is even seen as a pathway to status. The result has been what journalists are calling "an epidemic of violence" in the nation's schools. William Damon, a leading authority on child development in his book, *The Moral Child: Nurturing Children's Natural Moral Growth*, expresses the fear that the agendas of many schools "have been reduced from the pursuit of learning to the far less lofty goal of maintaining discipline and order."

A growing number of schools are responding with innovative programs to reduce violence through mediation and conflict resolution. This study guide, the fifth in the **RIGHT DECISIONS, RIGHT NOW** program, is designed to aid in this effort by suggesting ways of integrating the study of conflict and conflict resolution into your curriculum. Through the hands-on activities in the program, students will gain an understanding of the dynamics of human conflict, analyze methods of resolution, and learn new ways to control anger and manage conflict situations in effective, nonviolent ways.

The **RIGHT DECISIONS, RIGHT NOW** program is funded by the R. J. Reynolds Tobacco Company, which firmly believes that children should not smoke. The program, created for use with students in grades 6-9, is designed to help them become more effective decision-makers.

We encourage you to share this exciting program with your colleagues. Although the materials are copyrighted, you have permission to make as many copies as you need for educational purposes.

*Please take a moment to complete and return the enclosed response card.* Your comments help us to create programs that will continue to meet your needs. Returning this card also ensures your continued receipt of free educational programs in the future.

We hope you enjoy sharing this new unit of the **RIGHT DECISIONS, RIGHT NOW** program with your students and watching them gain new confidence and skill in addressing conflict in their lives.

Sincerely,

Dr. Dominic Kinsley  
Editor in Chief

**Lifetime Learning Systems, Inc.**

**... an Experience in Dynamic Education**

**79 Sanford St. • Fairfield, CT 06430 • (203) 259-5257**

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## Introduction

By grades 6 and 7 many students have become convinced that fighting is not only an acceptable response to conflict but that it actually provides the only way to maintain one's self-respect. The lesson is reinforced daily by what they witness on television, in the neighborhood or among their peers, and sometimes within the family. While no single classroom lesson or unit can counteract those influences, the study of conflict and conflict resolution can help students see that there are more satisfying and effective ways of dealing with conflict.

This study guide, the fifth unit of the RIGHT DECISIONS, RIGHT NOW program, is designed to strengthen students' decision-making skills through an examination of conflict and how it can be managed. Students will explore the basic dynamics of human conflict, analyze the factors that lead some conflicts to escalate, and consider ways of controlling anger and managing conflict situations more effectively.

The materials will dispel two common misconceptions about conflict. First, there is a tendency for young people to equate conflict with violence, in large part because it is violent conflict that captures our attention, both in real life and in the media. Quieter, nonviolent episodes may not even be recognized as conflict situations. There is also a general misconception that conflict is harmful — a state of discord that can threaten a family or a friendship, or that can destroy the unity of a community or nation. Students' work with the activities will make it clear that, while some conflicts are harmful, most are not. In fact, individual growth and social progress often emerge as healthy responses to conflict situations.

## Intended Audience

This program has been designed to be used with students in grades 6-9. The materials can be incorporated into social studies, health or life skills classes.

## Objectives

This fifth unit of the RIGHT DECISIONS, RIGHT NOW program is designed to help students:

- recognize that conflict is a natural and normal part of life.
- understand that a conflict and its outcome can be either healthy or unhealthy.
- become more aware of the dynamics of conflict in their own lives and in the world around them.
- identify the factors that cause some conflicts to become more intense or to escalate toward violence.
- analyze conflicts in their daily lives as well as in history, literature and the media by applying the same framework of questions to all examples.
- use role-playing scenarios to investigate effective methods of controlling anger and managing conflict situations.
- recognize that fighting and other forms of violence usually make conflict situations worse.
- consider ways they can reduce the incidence of fighting and other disruptive behavior in their lives, within their school and within the community.

## Program Components

1. Four activity masters to reproduce as individual and group worksheets.
2. This teacher's guide that contains:
  - suggestions for presenting each activity.

- ideas for extending each activity.
  - a list of resources.
3. A full-color wall poster with tips for keeping anger under control and managing conflict.
  4. A teacher response card that allows you to comment on the program. Please return this card to ensure that you remain on our mailing list and receive future free educational programs.

## Implementing the Program

### Group Work

The program is designed so that students work together on one portion of each activity (with the exception of Activity 3, which is a class activity) in groups of 5-6. You can have students remain in the same group throughout the program or change groups for each activity. Each group will have a group leader and a recorder. These positions should change each time, with the recorder reporting the group's conclusions to the class. Group leaders need to keep the group focused and working. The following rules should be established by the leader prior to any discussion.

1. Members are allowed to pass if they feel uncomfortable with a specific topic.
2. All members must contribute to the discussion.
3. No putdowns are allowed.

### Poster

The poster contains tips to help students learn to manage their anger and deal with conflict situations effectively. Display it in an area where it is easily accessible to students. Encourage them to check the poster often, making the tips on it a part of their daily life.

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### Follow-Up

Once you have completed this program with your class, encourage students to continue practicing their newly acquired conflict management skills. You can facilitate this by setting aside time for follow-up discussions once or twice a month when students can review the conflicts around them, how the parties involved dealt with the conflicts and whether or not the outcomes were healthy.

## Activity One

# Conflict Around You

### Objectives

- To generate student thinking about what conflict is and how it operates in their lives and in the larger society.
- To help students understand that conflict and its outcome can be either healthy or unhealthy.

### Introduction

A good way to introduce the activity is to brainstorm with the class on the meaning of conflict. Write the word conflict on the chalkboard and ask students to give you words that they associate with it. Then use the following series of questions to promote discussion.

- Is conflict the same as violence? Do we tend to think of conflict as something violent or unpleasant? Why do you think this is so?
- Is there conflict in nature? Between humans and nature?
- Even without words, how can we tell that a person is in a conflict situation? (body language, facial expressions)
- Do you see any difference between conflict involving two nations and conflict involving two people? What is it?

- What does a legislature such as the United States Congress have to do with conflict?

After discussing the questions and reviewing the words that students had associated with conflict, you might want to write a class definition of conflict. It should not be like a dictionary definition, but consist of statements they can associate with conflict. (E.g. "Conflict can involve individuals, groups or nations." "Conflict is not the same as violence.")

Distribute copies of Activity One. Encourage students to talk about each illustration, focusing on what makes the situation a conflict — perhaps even rating it on a scale of 1-10, with 10 being the highest, to show the degree of the conflict. The football scene would be the lowest, the scene of two kids physically fighting the highest.

As you discuss the illustrations, elicit from students that:

- a football game (or other sport) is a form of conflict since you have two opposing teams, both wanting to win, but that this involves competition on the field, which is acceptable and healthy.
- a courtroom scene represents the end result of a conflict — between a criminal and the law or between two or more parties in a lawsuit. These cases usually involve peoples' rights — either those of society (laws) or those of individuals (which encompass a large range, e.g. workers' rights, civil rights, slander, etc.). In these cases, the outcome is determined by a third party (court of law) rather than by individuals.
- two kids physically fighting is the most obvious of conflicts. It represents a conflict that has gotten totally out of hand. **Note:** Some students will argue, with the approval of parents, that fighting is the best

way to settle arguments. Be prepared to discuss this phenomenon with students, eliciting from them the unhealthy outcome from settling a disagreement in this manner.

- a holdup represents a conflict of interest between the thief (who wants the victim's property) and the victim (who wants to keep it). In most cases, for safety's sake, it is best to let the thief win.
- a parent/child argument is a common type of conflict, especially at this age, when students are trying to be more independent. Most students have firsthand experience with this type of conflict and will relate to it easily.
- the traffic accident represents a conflict where tempers can flare, with aggressive behavior often exhibited. Discuss how this type of behavior can easily get out of hand.

### In Your Group

Divide the class into groups of 5 or 6 students, with a leader and recorder for each group. Completion of the charts can be assigned as homework, with group members deciding how they will complete the tasks.

Go over the completed charts in class, asking each group to describe its findings. The process will help students develop a new awareness of how pervasive conflict is in people's lives and that it is possible to develop skills for managing conflict more effectively. Use the chart reports to draw out key ideas — for example, every TV drama or comedy, every movie, and every novel or short story is built around at least one central conflict; in fact, without the conflict, there is no story. In the group reports, look for examples that will illustrate both healthy outcomes (people involved resolve conflict peacefully and fairly; growth in making good

decisions is evident, etc.) and unhealthy outcomes (conflict ends in violence, frustration and dissatisfaction are evident, etc.).

### On Your Own

Ask volunteers to read their paragraphs to the class. Use the paragraphs and discussion to draw out generalizations, wherever possible rephrasing discoveries the students have made about conflict. Some possibilities are:

- We can have inner conflicts, e.g., whether to watch our favorite TV show or study for a test.
- Conflicts are about different beliefs or values — things we feel are important such as fairness, honesty, loyalty, respect and dependability.
- When we make decisions, we are resolving conflicts over beliefs or values, e.g., making a decision about whether or not to go with a friend to a party where you know there will be drugs.
- Conflicts and their outcomes can be either healthy or unhealthy. You really don't want to go to the party and argue with your friend about it. If you say "no" and don't do it, that's a healthy outcome. If you give in to pressure and go just because your friend is but resent going, that's unhealthy.
- Violence is an extreme way of trying to resolve a conflict: most conflicts are resolved without violence.

### Extending the Activity

1. Have students keep conflict journals for a few days, noting the conflicts they experience and how they are resolved (or what the alternatives are if not resolved). Let each student decide whether or not to record the most insignificant episodes, such as what color sweater to wear or what to have for lunch. After 3 or 4 days, ask them to report what

they have learned about conflict by keeping the journals. If the record keeping has been conscientious, they are likely to be surprised at how many conflicts they experience every day.

2. Challenge the class, working in groups, to explain why it would be important for each of the following to have an understanding of conflict: team coach, politician, business person, teacher, lawyer, priest/minister/rabbi, environmentalist, civil rights leader, prison warden, marriage counselor, playground director, student. The responses will reinforce the idea of the pervasiveness of conflict and the importance of being able to deal with conflict situations in constructive ways.

## Activity Two

# How Conflicts Get Out of Hand

### Objectives

- To educate students to the factors that cause some conflicts to become more intense or to escalate toward violence.
- To help students analyze conflicts in their daily lives.

### Introduction

The students' work with Activity One will make it clear that conflict is something we encounter every day in many different ways and that most conflicts are easily resolved — we have no trouble making the decision that settles the matter. Introduce Activity Two by pointing out that no two conflicts are exactly alike. Most arguments are settled peacefully, but now and then a dispute leads to a shouting match, often with hurtful statements being made, or someone throwing a punch. In this activity,

the class will look at some of the factors that can cause a conflict to escalate to the point where it gets out of hand.

Encourage students to give their opinions on how the factors included in the grid might influence the path a conflict takes. For example:

- Stress plays a role in the following scenario in which Mary, an eighth grader, and her mom have a conflict about smoking. *Mary's mom has been under a lot of stress at work. She comes home to find Mary's jacket thrown over a chair. She picks it up grumbling about how Mary never picks up after herself, when a pack of cigarettes falls out of the pocket. Mary's mom goes ballistic and accuses Mary of smoking, which she knows is wrong. Mary says the cigarettes belong to a friend, but her mom doesn't believe her. More heated words are exchanged. Mary gets angry and storms out of the house.*

Invite students to discuss how stress might have caused this conflict to get out of hand. What other factors might have been involved? (pride, misunderstanding, peer pressure) How might the conflict have been handled differently — by Mary? by her mom? Students might role play the scene from both perspectives — with the mother under stress and in a more temperate frame of mind.

### In Your Group

Have students work in their groups to analyze the conflict scenario. Students will recognize that, in this situation, a single factor may have led to fighting, or several factors may have been involved. Since we don't know what is in the minds of the participants, we can only speculate about what led to their actions. Peer pressure may have helped push either one, or both, into fighting. We can also speculate that Pat may have felt that self-



respect was more important than appearing cowardly by compromising or backing down. Misunderstandings or misperceptions may also have been involved. Encourage the groups to consider the problem from different perspectives.

Once students have analyzed what caused the conflict to get out of hand, encourage them to dig deeper into the conflict to learn about underlying factors that may have influenced it. Some questions they might ask are:

- Is Jamie usually a bully? Is this typical behavior for him?
- Does Jamie usually show disrespect for others?
- Have Jamie and Pat had an ongoing disagreement?
- Is Pat sensitive about his size?
- Has Pat been teased in the past about not standing up to someone like Jamie?

Depending upon your class, at your discretion you might want to add some social factors that might add a different dimension to the conflict.

- Jamie is a minority student; Pat is not.
- Jamie and Pat are a girl-friend/boy-friend duo who have just broken up.
- Jamie is a star on the football team; Pat is a quiet student.
- Jamie is in a gang; Pat is not.

### **On Your Own**

Stress to students that the important part of their journal entry is to get their feelings and observations down on paper, because writing helps us think more clearly about things. Inform students that their journal entries will remain private unless they want to share them: they will have to show them to you to prove that they made the entry, but even you will not read them unless given permission.

### **Extending the Activity**

1. Role play the scenario from the activity sheet from different perspectives to help students see how hidden factors can influence the escalation of conflicts. Have two students act out the situation with Jamie being a classmate that Pat doesn't know very well or like very much. Then act it out again, this time with Jamie being Pat's friend. How might the conflict be different?
2. Social scientists refer to a "conflict spiral" — a conflict that escalates or spirals toward violence as each side responds to the actions of the other. Have students select a conflict from a book, history, news story, film, etc. and diagram a spiral to show how each participant's response added to the escalation of the conflict.

## **Activity Three**

# **Reacting to Conflict**

### **Objectives**

- To help students learn and practice methods of controlling anger and managing conflict situations.
- To help students recognize that fighting and other forms of violence usually make conflict situations worse.

### **Introduction**

Before you begin this activity, review the main points that emerged from Activities One and Two — all conflicts have certain things in common and there are a number of factors that can lead to conflict getting out of hand.

**Note:** Activities Three and Four can be interchanged. You might want to present students with tips for managing conflict (Activity Four and Poster) before you do this activity.

Prior to passing out the worksheet, pair off students to work on specific role plays and establish role-play rules.

- Each role play must stop short of erupting into violence.
- The object of the role play is to manage the situation so that it does not get out of hand and to resolve it in a healthy way.
- Individual pairs will determine who plays which character and who works to control the conflict.

Invite a few pairs to role play their conflict situations for the class. The class can then analyze what each character did to defuse the conflict and whether or not the outcome was healthy. Encourage students to suggest other methods that might have been used to reach the same conclusion.

Once again, depending upon the configuration of your class and at your discretion, you might try overlaying some of these role plays with social factors that might alter the reactions of the characters due to stereotyping, lack of knowledge, emotional influences of personal relationships, etc.

### **Extending the Activity**

1. Encourage students to observe the conflicts they see around them — in school, at home, in the community, in the news or in TV programming. Students can report their observations to the class for discussion. They should include in their reports the nature of the conflicts, how they got out of hand, how the conflicts could have been handled in a more positive manner and whether social issues may have contributed to the conflict.
2. Interested students might look into the possibility of developing a conflict resolution program within the school. With the permission of school

administrators, they could research the mediation programs that are becoming increasingly popular. Two sources of information and materials are:

The National Association for Mediation in Education  
425 Amity Street  
Amherst, MA 01002

The National Institute for Dispute Resolution  
1901 L Street NW, Suite 600  
Washington, D.C. 20036

Keep in mind that these programs involve a good deal of preparation and training.

## Activity Four

# Managing Conflict

### Objective

- To strengthen students' sense of empowerment to resolve their conflicts in nonviolent and effective ways.

### Introduction

Initiate a discussion with students about managing conflict. You might begin by telling them that we are all creatures of habit and tend to react the same way to conflict situations because we are used to reacting that way. Invite students to share how they usually react — argue, walk away, keep quiet, fight.

Inform students that there are several ways to deal with conflict in a positive way. People have tried all these methods and have found them to work. Then pass out the activity sheets and discuss the tips for managing conflict with students, eliciting from them examples of when they might have seen these methods at work.

### In Your Group

As groups review the conflict situations presented, they should determine (1) what led to the escalation of the conflict; (2) which tips for controlling anger and managing conflict were used, or could have been used; (3) how the conflict was resolved, or could have been resolved. Conclude by reviewing with the class the basic points that have emerged from the four activities. Invite discussion of ways in which the students' growing understanding of conflict and conflict resolution can help them in their personal decision-making and in improving conflict situations within the school.

### Extending the Activity

1. Encourage each group to develop a scene that reflects a conflict situation within the school or the community. They can use the "big game" scenario as a model of what elements to incorporate. If some students feel more comfortable using that fictitious scene, this should be permitted.
2. View a film or TV drama (or comedy) that does not depend on a violent settlement to analyze the methods used to resolve the central conflict and any secondary conflicts that occur.

### Resources for Teachers

M. O. Baker, *What Would You Do?* (Midwest Publications, 1989). Reproducible activities involving hypothetical moral conflicts.

*Tug of War: Strategies for Conflict Resolution* (NY: Human Relations Media, 1991). VHS videocassette and guide.

Barbara Sprague Newsam, *Complete Student Assistance Program Handbook* (Center for Applied Research in Education, 1992).

B. Johnson, ed., *Dealing with Social Problems in the Classroom* (Dubuque, Iowa: Kendall/Hunt Publishing Company, 1982).

U.S. Department of Health, Education & Welfare, *Violent Schools — Safe Schools: The Safe School Study Report to Congress* (Eric Document Reproduction Service, Number ED 149,464, 1979).

E.L. Feindler & R.B. Ecton, *Adolescent Anger Control* (NY: Pergammon Press, 1986).

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## Activity One

# Conflict Around You

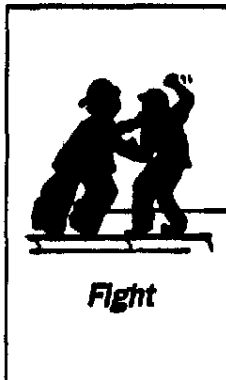
Conflict is a part of life. It's all around you and takes many forms, from a war between two nations to a quarrel between two friends. Look at the pictures below. Which ones are pictures of conflict? Be ready to give reasons for your answers.



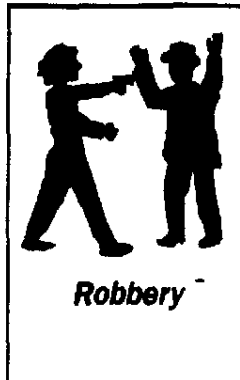
**Football**



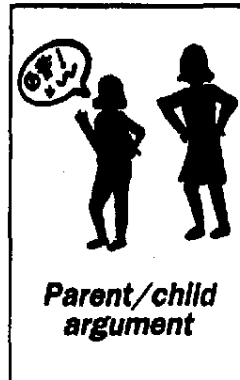
**Courtroom**



**Fight**



**Robbery**



**Parent/child argument**



**Automobile Accident**

When you need to deal with conflict, it helps to know how conflict works. Use the six questions listed here to start thinking about conflict. How would you answer these questions for each conflict shown above?

1. Who is involved?
2. What is the conflict about?
3. How do you know it is going on?
4. How is the conflict expressed (arguing, shoving, fists, weapons)?
5. What are the choices for settling it?
6. Is the outcome likely to be healthy or unhealthy?

## In Your Group

**Group Leader:** Get your group together. Find an example of conflict for each of the categories listed in the chart below. Then answer the six questions for each conflict.

**Recorder:** Write your group's answers to each question below on the back of this sheet. Report your group's findings to the class. Share things you learned about conflicts that you hadn't thought about before.

<i>Example of Conflict in</i>	<i>News Item (TV/newspaper)</i>	<i>TV Drama or Comedy</i>	<i>Novel or Short Story</i>
1. Who is involved?			
2. What is it about?			
3. How do you know it's a conflict?			
4. How is it expressed?			
5. What are the choices for settling it?			
6. Is the outcome likely to be healthy or unhealthy? Why?			

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## On Your Own

Write a paragraph about a conflict you've seen or been involved in. It can be a fight, an argument or an inner conflict. It can involve yourself, a friend or classmate, your parents, a brother or sister, anyone. Try to answer all six questions. Share your example with the class and compare your conflicts.

## Activity Two

# What Causes Conflicts To Get Out of Hand

You know that anger can cause a conflict to get out of hand. You can see the anger in a fist fight or hear it in a shouting match. But other things are involved, too — things you can't easily see. Look at the words in the grid here. Discuss with the class how each one might cause a conflict to get out of hand.

prejudice	frustration	betrayal	loyalty
stress	hopelessness	peer pressure	pride
misunderstanding	disappointment	ignorance	fear
embarrassment	meanness	jealousy	disrespect

## In Your Group

**Group Leader:** Read the following story to your group:

*Jamie joins his friends, who are standing in front of Pat in the lunch line. Pat complains to Jamie about cutting in. Jamie acts tough and says, "So, what are you going to do about it?" They argue back and forth. Then Jamie gives Pat a shove. Pat shoves back. Some of the other kids in line begin to urge them on. Pat, who is a lot smaller, begins to get really angry. Jamie just laughs. Pat throws a hard punch and the fight is on — until a teacher steps in.*

Discuss in your group what might have caused this conflict to get out of hand. Which of the above words can you apply to this situation? How might they affect the actions of each character?

**Recorder:** Record the group findings. List the things that caused the conflict to get out of hand and how these things could have affected the characters' reactions. Report the group's findings to the class.

## On Your Own

Think about a conflict that you have been involved in. Write a journal entry about it — including what caused it, how it got out of hand and how your actions contributed to it escalating. Focus on the emotions you were feeling at the time.

## Activity Three

# Reacting to Conflict

All of us experience conflict in our lives. But we usually don't take time to analyze it to see how and why we reacted the way we did. The scripts here will give you a chance to explore different ways people react to conflict, helping you to better understand your own reactions to it.

Pair up with a classmate to role play one of the conflicts described here. You will need to work in pairs. First, play out the situation to show how things could get totally out of hand. Then replay the situation twice, letting each character take a turn trying to defuse the conflict. Before beginning, decide which character will try to defuse the situation. Write down as many ways of reacting as you can think of that would help settle the conflict. Then role play the situation again — this time with the other character trying to resolve the conflict. Use the back of this sheet if you need more space.

### CONFLICT I

**Characters:** Parent and 14-year-old child, Jackie

**Setting:** Home

*Jackie comes into the house just before dinnertime, dragging a backpack.*

**Parent:** "Where have you been?"

**Jackie:** "Out."

**Parent:** "What do you mean, 'out'?  
Do you realize what time it is?"

Ways Jackie can react:

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Ways Parent can react:

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### CONFLICT II

**Characters:** Students, Nicki and Kim

**Setting:** School

*Kim is at a friend's locker talking to a group of kids.  
Nicki walks up to talk to Kim.*

**Nicki:** "I hear you've been telling lies about me."

**Kim:** "Who told you that?"

**Nicki:** "So, it's true!"

Ways Kim can react:

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Ways Nicki can react:

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### CONFLICT III

**Characters:** Siblings, Lu and Bobbi

**Setting:** Home

*Lu comes racing into the family room. Bobbi is watching a video.*

**Lu:** "How long are you going to be?"

**Bobbi:** "A while. I just started watching this movie."

**Lu:** "But my show is coming on in five minutes."

Ways Bobbi can react:

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Ways Lu can react:

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### CONFLICT IV

**Characters:** Classmates, Jody and Andi

**Setting:** School

*Before classes began, Jody hung a poster asking for votes in a prime spot in the cafeteria. At lunch time, it had been replaced with Andi's poster. Jody goes over to Andi's table.*

**Jody:** "Andi, why is your poster there?  
What happened to mine?"

**Andi:** "I changed them. Yours is over there."

**Jody:** "I had mine there first."

Ways Andi can react:

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Ways Jody can react:

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## Activity Four

# Managing Conflict

Managing conflict is a skill — and it takes practice. Listed here are some tips that will help you to manage any conflict situation you find yourself in. They have been tried — and they work!

- 1. Keep cool.**  
When you get "hot," find the technique that works best for you to cool down — count to ten, sing, take a walk, do some shadow boxing, etc.
- 2. Talk it over.**  
Listen to the other person's point of view.
- 3. Focus on the problem — not the person or group.**  
Make sure you know what the conflict is about. Deal with that.
- 4. Look for a compromise.**  
What will satisfy both sides?
- 5. Know when to walk away.**  
If others are about to fight, keep out of it. Don't make things worse.
- 6. Be a leader.**  
When tempers are high, urge others to chill out.
- 7. Be a friend.**  
If a friend is about to fight, get him/her out of there.
- 8. Work with others.**  
Encourage your friends and classmates to really work at stopping conflict from getting out of hand.
- 9. Be responsible.**  
If a conflict is getting out of hand, report it to someone who can help.
- 10. Practice real courage.**  
Have the courage to try to work it out. Remember that fighting only makes things worse.

## In Your Group

**Group Leader:** Get your group together to review the ten tips for managing conflict situations. Then, as a group, discuss the conflict situations presented here. Which tips would the group recommend for managing each conflict? Why those specific tips? Would others work as well? Why or why not?

**Recorder:** Record the tips recommended by the group for managing each conflict, along with the reasons why they were chosen. Report the findings to the class.

### CONFLICT I

On the day of the big game, the gym was packed with students from rival schools Central and Tech. It was a fast-paced, exciting game, with the lead bouncing back and forth. Tech won by one point, a foul shot made within fifteen seconds of the end of the game. After the game, Sandy and Lee, who were students at Central, were badmouthing the player who had made the winning shot. Kim and Lauren, who were students at Tech, overheard Sandy and Lee. They made a snide remark about a Central team player. Kim and Lauren answered back.

The argument continued. Pretty soon, other kids from both schools began getting involved. Lee gave Kim a push and Lauren took a swipe at Sandy. Then the situation got really out of hand — a fight that took the security guards twenty minutes to settle down.

### CONFLICT II

Susan and Maria, two good friends, are on their way to the mall. Susan tells Maria that she told a group of kids from school that they would meet them there. Maria is upset because she thinks those kids get into too much trouble. Susan disagrees and argues that they are the "in crowd" and they will be lucky to join them. Maria still isn't happy, but goes along.

At the mall, the group dares Susan and Maria to "lift" a bottle of perfume from the cosmetic department. Susan takes the dare and heads for the cosmetic department. Maria grabs her and tries to physically stop her. Susan gets really angry and shoves Maria away.

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HERE



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# Ways to Manage Conflict

If you know how to manage conflict and remember to keep your temper under control, you can find ways to keep conflict situations from getting out of hand.

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## 1 • Keep Cool



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## 2 • Talk It Over

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3 • Focus on the Problem  
— not the person or group

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4 • Look for a Compromise

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5 • Know When to Walk Away

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6 • Be a Leader

---

7 • Be a Friend

---

8 • Work With Others

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# 9 • Be Responsible

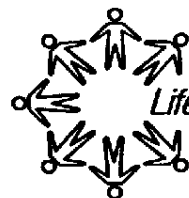
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# 10 • Practice Real Courage



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Fairfield, Connecticut 06430



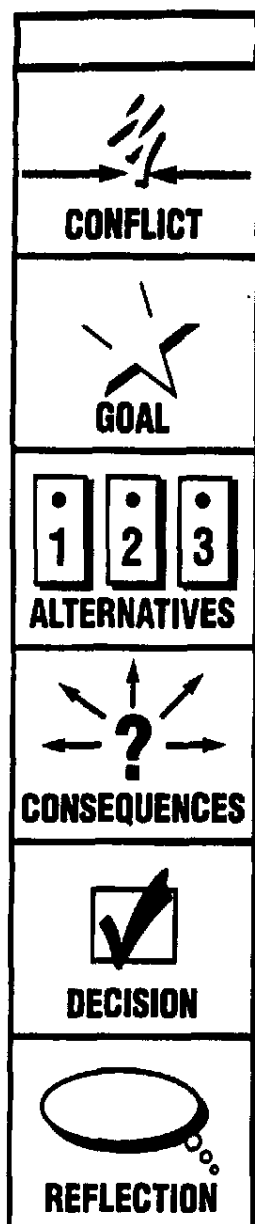
# FREE INSIDE!

**Educational program to help students:**

- learn about peer pressure and peer influences.
- make the best decisions for themselves.

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# Dear Educator:

Young people entering the early years of adolescence today face a myriad of choices — choices that can affect the rest of their lives and choices that most are ill-prepared to make. Unable or unwilling to turn to parents for guidance, they are increasingly susceptible to the pressures and influences of peers who are equally uninformed about life's challenges and questions.

Recent research in adolescent behavior and development shows that one of the most important contributions educators can make to young people is to help them develop their capacities as decision-makers. According to Dr. Richard P. Keeling, a leading specialist in the field of adolescent health, young people who are most at risk are those most lacking in the capacity to make decisions. He warns that "levels of self-esteem and self-determination — the ability to make decisions based on an internal, personal framework of values — among our teenagers are dangerously low."

This study guide is part of the **RIGHT DECISIONS, RIGHT NOW** program which is designed to help students develop the capacity to make decisions — the decisions that are right for them. The program is funded by the R.J. Reynolds Tobacco Company, which firmly believes that children should not smoke. Developed for use with students in grades 6-9, the activities in this program help students look at some of the decisions they might face this coming year. They will examine the factors that influence decisions, learn skills that help them make decisions and, finally, make some personal decisions for the coming year.

We encourage you to share this exciting program with your colleagues. Although the materials are copyrighted, you have permission to make as many copies as you need for educational purposes.

*Please take a moment to complete and return the enclosed response card.* Your comments help us to create programs that continue to meet your needs. Returning this card also ensures your continued receipt of free educational programs.

Start the year off right for both you and your students by sharing this program with them and watching them grow in confidence as they learn to make the right decisions, right now.

Sincerely,

Dr. Dominic Kinsley  
Editor in Chief

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**LIFETIME LEARNING SYSTEMS, INC.**  
... an Experience in Dynamic Education

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## INTRODUCTION

**RIGHT DECISIONS, RIGHT NOW** offers suggestions and materials to help students acquire better decision-making skills. The program is based on the following premises:

- All students can develop sound skills as decision-makers.
- Schools can help students develop these skills by providing as many guided experiences in decision-making as possible.
- As students gain greater mastery of decision-making, they will become better able to resist the negative influence of peers.

In order to become better decision-makers, students must first come to grips with the outside forces that can lead them to make choices they will later regret. The most obvious force is **peer pressure**. Adolescents worry that they may be taunted or teased into doing something they don't want to do or that they know is wrong. (Ex. "My friends smoke. They are pushing me to start. I don't want to be different, so I think I'll do it.")

Students also need to understand the more subtle force of **peer influence**. Young people who engage in risk behaviors often do so because they assume this is something they have to do in order to be accepted, to be liked or to have and maintain friendships. No overt pressure is applied; instead, the individual creates an internal pressure out of the desire to fit in. (Ex. "The cool kids in school smoke. I want to be cool, too. I think I'll start smoking, so I can be like them.")

**RIGHT DECISIONS, RIGHT NOW** is designed to help students become more aware of peer influence and how to prevent it from dictating their decisions. The activities in this kit are designed to take students step-by-step through the decision-making

process. With guidance and practice, they will become more adept at identifying conflict, stating goals, analyzing alternatives by considering consequences and evaluating the influence of peers, parents or other adult family members and the media.

## INTENDED AUDIENCE

This program has been designed to be used with students in grades 6-9 in social studies or health classes. It is important to reach students in these grades as they are entering adolescence and are beginning to make decisions that can have prolonged effects on their lives. The activities will help students develop strong decision-making skills so they are able to make the right decisions for themselves — regardless of outside pressures and influences.

## OBJECTIVES

**RIGHT DECISIONS, RIGHT NOW** is designed to help students:

- understand the distinction between peer pressure and peer influence.
- recognize ways in which both peer pressure and peer influence can affect the decisions they make.
- discuss shared concerns about decisions they may face during the coming year.
- analyze the mental steps involved in making a decision, and apply those steps to important personal decisions.
- consider the consequences or possible alternatives in making any decision.
- recognize that even the best decisions may have some negative outcomes.
- establish specific and important decisions (goals) for the coming year.
- evaluate ways to utilize positive influence as well as ways to han-

dle negative influences that might affect the achievement of personal goals.

- gain confidence in their ability to make the best decisions for their lives now and in the future.

## PROGRAM COMPONENTS

This program contains the following components:

1. Four activity masters to reproduce as individual worksheets for students.
2. This teacher's guide which contains:
  - A statement of program objectives.
  - Background information.
  - Suggestions for presenting each activity.
  - Ideas for extending each activity.
  - A list of resources.
3. A poster that encourages students to think about the decisions they will need to make this year.
4. A teacher response card that allows you to comment on the program. Return this card to ensure that you remain on our mailing list and receive future free educational programs.

## USING THE PROGRAM COMPONENTS

### Poster

Display the poster in a prominent place in your classroom. You can use it as an introduction to the program and as a reminder to students of the questions they should ask themselves when faced with important, tough decisions. Tell students that making the right decision involves skill and practice. As you discuss the poster, help students realize that the steps to making a decision illustrated on it will help them gain the skills they need to make a decision. The practice will

come with applying these questions to the tough decision-making situations they will face all year.

## ACTIVITY A YEAR OF DECISIONS



Introduce the activity by spending a few minutes talking in general terms about situations the students feel they might face in the coming year, especially those that will require them to make difficult decisions. Ask if anyone is concerned about the pressures and temptations that lie ahead. Do they feel uneasy about being pressured into doing something they know is wrong? After some initial hesitation, the students will begin to talk about some of the anxieties and uncertainties they feel.

Let the students know that the activities they will be working on represent an opportunity to think about and discuss some of the issues and questions that concern them most. Make it clear that they are not in a test situation and that you are not looking for right or wrong answers. Use whatever techniques work best for you to help the students feel comfortable and willing to address these matters in an honest and serious way.

As you distribute copies of Activity One, explain that it is designed to start them thinking about the kinds of decisions they might face during the coming year.

### Part I

Instruct students to complete only the first part of the activity, thinking about each situation and answering honestly. They should check the box that identifies how they "feel" rather than what they think should be the answer. This exercise will help them better understand themselves, a first step in learning how to handle difficult decisions.

### Peer Pressure/Peer Influence

Before completing Part II of the activity, introduce the concepts of **peer pressure** and **peer influence**. First ask volunteers to give a definition and one or two examples of peer pressure. Teasing, cajoling and challenging are the key factors. Most students are familiar with these methods of pressure. Point out that peer pressure is not always verbal. Dropping someone from a friendship or group, for example, can produce a strong feeling of pressure.

To help the class understand peer influence, ask about their tastes in such areas as music, clothing styles, hair styles, things to do for fun, etc. How did they develop these particular tastes? Point out that these choices are rarely the product of peer pressure. Instead, we are all influenced by peers. We talk, dress, act and do things according to the standards of our group of friends.

As you talk about peer influence, share the following information with students:

- Both peer pressure and peer influence can be either positive or negative forces in our lives.
- Conforming to group standards is perfectly healthy and normal — for adults as well as teens. A business executive is not likely to wear shorts and a sweatshirt in an office; this would set the person off as someone strange or different.
- It's helpful to think of peer influence as pressure we put on ourselves. We want to be accepted, to fit in, to be liked, so we act in ways that will ensure this, sometimes even when it means doing something we feel we shouldn't.

Once students understand the difference between peer pressure and peer influence, have them look at the situa-

tions in Part I again, identifying which ones involve peer pressure and which show peer influence. Situation 3, stealing the cassette; situation 4, going to an unchaperoned party; situation 6, the friend trying pot; and situation 7, friends smoking, represent situations in which there is overt pressure. In the other situations, peer influence is operating. The decision maker is motivated by the desire to be accepted or not to be isolated.

### Part II

Before students begin Part II of the activity, encourage them to look at their responses to Part I and decide whether their decisions are more affected by peer pressure or peer influence. When they have completed Part II, encourage them to talk about the situations they described and the kinds of pressures and influences that might be involved. Students are likely to notice that they worry less about peer pressure than they do about losing friends if they don't go along with what the friends want to do.

Emphasize that the fear of losing friends or not fitting in is a serious matter and one that the class will address in the next activities. At this point, simply learning that others share the same uncertainties may provide an important feeling of relief.

### Extending the Activity

1. Divide the class into four or five groups. Have each group brainstorm ways in which peer pressure and peer influence can be positive forces. For example, how can their own actions serve as a positive model for their peers and for younger students both in terms of what they do and what they avoid doing.
2. Apply the concepts of peer pressure and peer influence to larger social issues. How, for example, can these have either a positive or negative impact on the envi-



ronment of the school or the community? Identify acceptable ways of behaving in terms of littering, recycling or acting to improve the appearance of one's surroundings. Then plan ways to use positive peer pressure and peer influence to incorporate these behaviors as acceptable ways of acting.

## ACTIVITY PLAY IT OUT

2

Introduce the activity by dividing the class into four or five groups. Explain to students that they are going to have a chance to observe decision-making in action. Pass out copies of the activity sheet and have each group develop its own skit, following the instructions. While it's desirable to have each group work with a different decision topic, it is more important that the students feel the topic is important and meaningful to them — even if all groups end up with the same topic.

### Part I

Be available to answer questions or assist groups that may need help. Allow at least 15 minutes for the groups to meet and plan their scenes. The actual role play for each group should last a maximum of ten minutes. The role play can be entirely ad-lib, with each student playing the assigned part as he or she perceives it. However, some groups may want to develop more elaborate plans with a written dialogue. Either approach will work.

As skits are performed, you might want to act as director to keep the scenes focused and moving. During performances, you'll find that some "actors" may find that the chemistry

of conflicting opinions and values leads them to say things they hadn't intended and even to change their position on an issue. Try to bring out these instances in your follow-up discussion.

### Part II

Make additional copies of the activity sheet so that students can fill out a separate response form for each skit. Use these responses as the basis for discussion. It's important to debrief each skit as it is completed. Also, in discussing the response forms, be sure that the student actors receive some positive reinforcement for their efforts.

After all skits have been presented and discussed, use the following questions for wrap up:

1. To what extent do you think the decisions were affected by (a) peer pressure, (b) peer influence?
2. Was there evidence that either peer pressure or peer influence can be positive? For example, did Sandy or other friends try to push or persuade Chris to make the decision that was best for him/her?
3. Who had the greatest influence on the decision?
4. If this had been your decision to make, do you think you would be influenced more by your parents, an adult family member, your best friend or other friends and acquaintances? (Answers to this last question may be quite varied. Younger students tend to feel that the influence of parents is strongest, but this feeling changes for older students who are more influenced by friends.)

## Extending the Activity

1. Positive peer influence has been a valuable component of several drug abuse prevention programs. You might want to reinforce this factor by having students polish skits that emphasize positive peer pressure and influence and perform them again for a school assembly or for younger students.
2. Encourage students to watch their favorite television sit-com or drama to look for examples of how the pressure or influence of peers can affect important decisions. As students report on these shows, discuss the extent to which such television presentations adequately reflect the realities of life.

## ACTIVITY THOSE IMPORTANT DECISIONS

3

To introduce the activity, you might want to develop a hypothetical situation to keep the discussion of decision-making from becoming too abstract. Either invent your own case or use the example of Kim, a 9th grade student, who has to decide whether to study for a difficult test or to go to a movie with friends.

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RIGHT  
DECISIONS  
RIGHT  
NOW

## Part I

Using your hypothetical case, go over each of the decision-making steps, emphasizing the following points to students.

1. The actual decision-making process is not quite as neat or simple as the steps outlined. In thinking about a decision, Kim might jump around from consequences to objectives to goals and then back to consequences. In addition, in real life, the whole process is often shortened by making a sudden decision on impulse or out of habit. However, when faced with an important decision, it helps to go through each of these steps.
2. Making a decision involves both factual information and values — the things the decision-maker considers most important. Kim, for example, has to know the factors that affect the decision and the consequences of the decision. What is Kim's present grade in the subject? What affect will the test have on the grade? Values are also central to the whole process, such as the kinds of rewards that are most important to Kim. What will provide the greatest immediate satisfaction? Does one activity have more value for future applications, such as college admission?
3. Even when we choose the alternative that seems best, there is likely to be at least one negative consequence. In our example, Kim may select a movie because being with friends is the most important thing. A low grade on the test may be the negative consequence. Use this idea to make the point that gaining skill in decision-making also means learning to accept all the consequences of a decision.
4. Pressures and influences from friends can also affect the outcome of a decision. For

instance, the pressure of friends to go to a movie may affect the final decision even though Kim knows the extra study time would make an important difference in the final grade.

## Part II

Allow students as much time as they need to complete the decision-making chart. Encourage them to think through every step of the process, using the back of the sheet if they need more space.

Some students may be reluctant to share with the class a decision involving a family matter or some other deeply personal topic. While it is important to maintain an atmosphere of free and candid discussion, privacy must also be respected. Use judgment in addressing sensitive issues.

In discussing the completed charts, ask such questions as:

1. How were your personal values involved — the things you consider most important, including how you feel about yourself?
2. Did you find conflict between values? (Ex. being loyal to a friend vs the value of honesty.)
3. In what ways do you think peer influence might affect your decision?
4. What can you do so that neither peer pressure nor peer influence leads to a wrong decision?
5. How might you use peer pressure or influence to help you make the right decision?

In discussing the last question, help students see that thinking through the decision-making steps, especially weighing the consequences, can help. It would also be useful to spend a few minutes talking about how members of the class can help each other make the best decisions.

## Extending the Activity

1. The experience of keeping logs will make students aware of how decision-making pervades their lives. Have students keep daily "decision logs" for one week, recording decisions made, how choices were made and what peer pressures or influences were involved. The decision topics do not need to be life-shaping matters but rather everyday occurrences. (Ex. whether to buy a new tape or save the money; whether to finish homework or watch TV; whether to buy a new outfit or save the money for vacation.)
2. Interviewing parents or other adult family members can help open communication between students and families concerning the making of decisions. Students can ask older family members about important decisions they had to make in their lives, including the factors that influenced the final decision.

## ACTIVITY REACH FOR IT



Introduce this activity by reviewing the decision-making process and the generalizations that have emerged about peer pressure and peer influence. Then tell the students that they will have a chance to apply what they've learned to decisions of their own for the coming year.

Initiate a discussion about goals the students might like to set for the coming year. Be sure students understand that these goals can be either something they would like to achieve or something they would like to avoid. Give examples for each, based on your knowledge of what is of greatest importance to the members of this particular class.

(Ex. doing well in school, avoiding the use of drugs, volunteering time to work with younger students, etc.)

## Part I

Distribute the activity sheets and allow time for students to list their goals. Remind them that the goals should be important to them. Encourage them to be realistic and to make the goals as specific as possible.

## Part II

Although the analysis sheet looks simple, it requires serious thought and imagination. Each student must try to imagine exactly what a best friend, other friends and parents or adult family members will do or say or expect that might affect this decision. They should also consider outside influences. Frequently, this act of reflecting or imagining is an eye-opening experience because it helps students think through the consequences of any choice.

When everyone has completed the analysis sheet, use the following ideas to guide discussion:

1. Some students are likely to find that friends, even a best friend, might be a negative influence. Ask the class if this means that the fear of losing a friend or not being accepted may lead them to do something they don't want to do. How can they overcome this anxiety about going against friends? Help students conclude that true friends will not press them to do something both parties think is wrong. Also, help students realize that doing what's best for one's own life and future is more important than going along with something friends are doing.
2. Some students will find that a parent or some other adult provides a strong influence as a role model. Encourage them to talk about this kind of positive influ-

ence and how it can help them overcome self-doubt or other pressures.

3. In some areas of behavior, there is often a powerful connection between media images and peer influence. The connection is worth exploring. Many young people get their ideas of what is neat or cool from the media, especially television and film. (Ex. violence such as fights or reckless car rides.) Discuss how these media messages influence actions.

## Extending the Activity

1. Literature can provide your students with valuable insights into growing up, setting goals and making life-shaping personal decisions. Biographies and autobiographies are particularly useful in creating models of the moral courage needed to make difficult decisions or to overcome negative influences.
2. Initiate a discussion about a goal to get in good physical shape, a decision that is made by many students in this age group. Focus on reasons why a person might make this decision — peer pressure (teasing about weight, the way one looks in clothes, going out for sports, etc.); peer influence (others think I'm fat or out of shape, all the popular kids are slim, etc.). Also talk about the choices and consequences that are pertinent to this decision. (Ex. diet, exercise, feel better, look better, more energy, anorexia, bulimia, use of drugs such as steroids or speed.)

## RESOURCES FOR TEACHERS

*Handling Peer Pressure*,  
Weymouth, MA, Life Skills  
Education, Inc., 1989.

Dr. Richard P. Keeling, "Student Health in the 1990s," *The Chronicle of Higher Education*, Oct. 9, 1991, Vol. XXXVIII, No. 72.

Dana G. Kurfman, ed., *Developing Decision-Making Skills*, Washington, D.C., National Council for the Social Studies, 47th Yearbook, 1977.

National Institute on Drug Abuse, *Adolescent Peer Pressure*, Rockville, MD, U.S. Department of Health & Human Services, 1988.

Ardyth Norem-Hebeisen and Diane P. Hedin, "Influences on Adolescent Problem Behavior: Causes, Connections, and Contexts," in National Institute on Drug Abuse, *Adolescent Peer Pressure*, Rockville, MD, U.S. Department of Health & Human Services, 1988, p. 21 f.

Sharon Scott, *Peer Pressure Reversal*, Amherst, MA, Human Resource Development Press, 1988.

E.E. Werner and R.S. Smith, *Vulnerable But Invincible: A Longitudinal Study of Resilient Children and Youth*, NY, McGraw-Hill, 1982.

Video: *Coming of Age* (In Spanish and English), Washington, D.C., The National Coalition of Hispanic Health & Human Services Organizations (COSSMHO), 1990.

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**RIGHT  
DECISIONS  
RIGHT  
NOW**

# check Your Game Plan

Some decisions are easy to make. Others are tough. Use these steps to help make the right decisions for yourself—especially those tough ones.

**2 What's  
Your**

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**1 What's  
The  
Conflict?**  
Why do you  
need to make  
a decision?

What do  
you want to  
happen?

# 3 What Are Your Options?

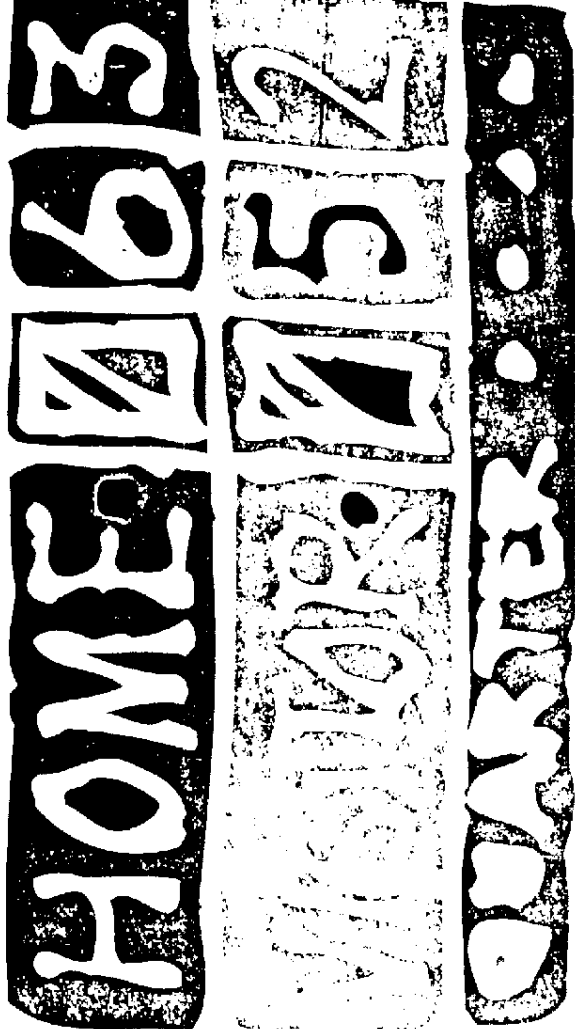
What can you do?

Do you follow the crowd

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# 4 What Are The Consequences?

What good or bad  
things can happen?



# 5 What's Your Decision?

What did you  
decide to do?



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**Relief  
On It!**

**Did you make  
the right  
decision?**

**RIGHT  
DECISIONS  
RIGHT  
NOW**

51604 6058

# ACTIVITY

# 1

## A YEAR OF DECISIONS

RIGHT  
DECISIONS  
RIGHT  
NOW

*You'll be making many decisions this year. Some of them will be easy. But others will be more difficult. You may find that peer pressures and influences get in the way, affecting your ability to make the decision that is best for you.*

### Part I

*The situations below reflect some of the pressures and influences you might encounter. Read about each one. Mark the box that shows how you feel about the decision.*

	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
1. All the popular kids in school drink. You want to belong, but you refuse to start drinking just to be accepted.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. You are at a party where a lot of kids are using cocaine. You're not into that stuff, so you leave.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. You're at a mall with two friends. They challenge you to shoplift a cassette. When you resist, they tease you, so you steal a cassette to shut them up.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. A friend is throwing a party while his parents are out. All your friends are going. You know your parents will object. Your friend argues that what they don't know, won't hurt them. You opt not to go to the party.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. You want to fit into a group of kids, most of whom smoke. You think about starting so they'll accept you.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Your best friend is trying pot and gets angry when you won't try, too. You don't want to lose a friend, so you join in.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. You meet some of your friends after school. They're all smoking. One of them offers you a cigarette. You don't want one, but they're all watching, so you take it.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Part II

*Think about the decisions that needed to be made in the above situations. Choose two decisions that you think you might face this year. List them. Then think about a situation in which you might face one of them. Describe the situation and list the pressures and/or influences that might affect your decision.*

#### Decisions

- \_\_\_\_\_
- \_\_\_\_\_

**Situation**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Pressures**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Influences**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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# ACTIVITY 2

## PLAY IT OUT

RIGHT  
DECISIONS  
RIGHT  
NOW

*During the coming year, you will most likely be involved in situations where important decisions need to be made. Your decisions will probably be influenced by a variety of factors. The important thing is to make decisions that are right for you.*

### Part I

*Analyzing situations can help you see them more clearly and help you better understand all the factors that might influence decisions. Give it a try, and see what you learn. Divide into small groups, and create a skit for a situation in which someone your age might face a difficult decision. Use the guidelines given here. Then perform the skit for your classmates.*

#### Characters:

Decision-Maker — Chris Dobbs  
Influencers — Best friend,  
Sandy; an adult family member;  
other friends, acquaintances

#### Conflict:

Determine a decision that  
Chris needs to make. Choose  
a topic that is important to  
you (drugs, shoplifting, drink-  
ing, smoking, friendships,  
etc.).

#### Plot:

Each actor should play the role  
in a way the group feels  
reflects real life. Be sure to  
include pressures and influ-  
ences that might affect the  
decision.

### Part II

*Use the following criteria to analyze each group's skit.*

1. Do you think the decision was realistic? Why or why not?

2. How was Chris' decision influenced by:

a. Sandy

b. an adult family member

c. other friends

d. outside influences

3. Suppose this had been your decision to make. Which of the following do you think would affect your decision the most?

a. the advice of your best friend

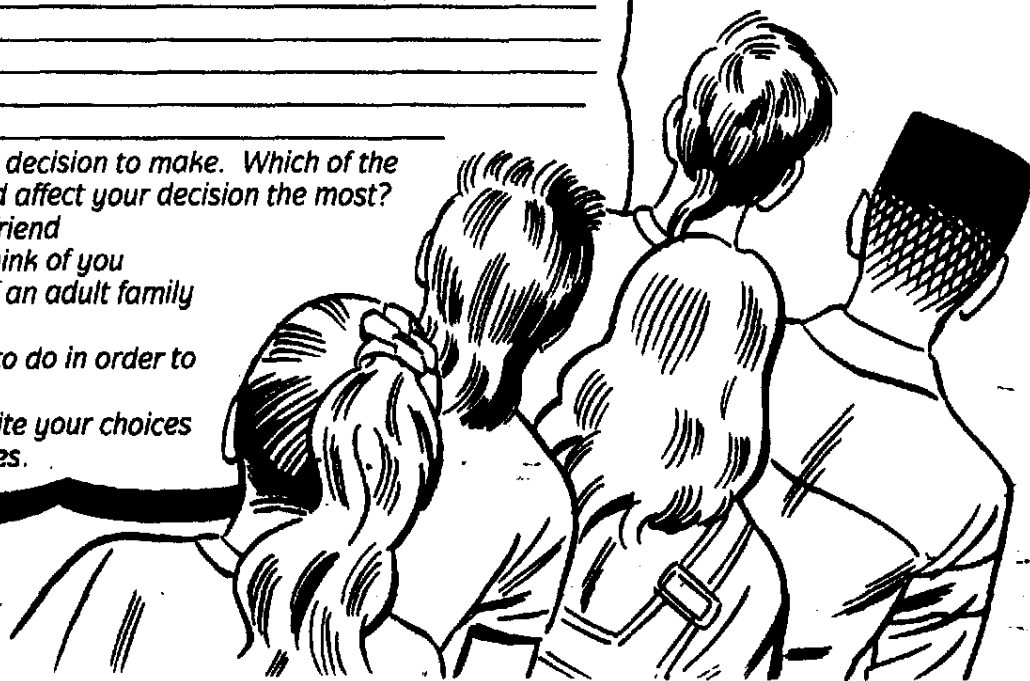
b. what other kids might think of you

c. the advice or reaction of an adult family member

d. what you feel you have to do in order to be accepted and liked

*Use the back of this sheet to write your choices and the reasons for those choices.*

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# ACTIVITY 3

## THOSE IMPORTANT DECISIONS

RIGHT  
DECISIONS  
RIGHT  
NOW

*You make some decisions automatically. You don't stop to think about them before reacting. Others require lots of thinking. But, both kinds involve a complicated mental process. Every time you make a decision, your mind goes through some version of the following steps:*

- Step 1:** Conflict — Why do you have to make a decision?
- Step 2:** Goal — What do you want to have happen?
- Step 3:** Alternatives — What are your choices?
- Step 4:** Consequences — What good or bad things can happen?
- Step 5:** Decision — Making your choice.
- Step 6:** Reflection — How do you feel about your choice?

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### Part I

*Think about an important decision that you have — or think you might have — to make. Work out your probable decision by completing this decision-making chart.*

1. What is the conflict? \_\_\_\_\_
2. What is your goal? \_\_\_\_\_
3. What are your alternatives?
  - a. \_\_\_\_\_
  - b. \_\_\_\_\_
  - c. \_\_\_\_\_
4. What are the positive and negative consequences of each choice?

Positive	Negative
a.	
b.	
c.	

5. What choice did you make, and what persuaded you?  
\_\_\_\_\_

6. How do you feel about your decision? Why?  
\_\_\_\_\_  
\_\_\_\_\_

### Part II

*Review each step in your decision-making process. Did you make the right decision for yourself regardless of outside pressures and influences? If your answer is "yes," GREAT! If "no," what can you do to help you make the right decisions?*

# ACTIVITY 4

## REACH FOR IT

RIGHT  
DECISIONS  
RIGHT  
NOW

*You know about the decision-making process — the steps that go into making decisions as well as pressures and influences that may affect them. Now you can use that knowledge to help you make the decisions that are right for you.*

### Part I

*Sometimes you need to make decisions on the spot. Other times you can put a lot of thought into your decisions. Some major ones can be made ahead of time. Look at the year ahead, and make decisions about some things you would like to achieve or some things you would like to avoid. List two or three of those decisions, and plan to stick to them.*

*Achieve*

*Avoid*

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Part II

*Select at least one of your decisions from each category. What pressures and influences can help you fulfill that decision? What pressures and influences might make it more difficult? Use the chart here as a guide, and write your comments in the appropriate spaces. Then look back at what you wrote. What did you learn? How will this knowledge help you make the right decision for you?*

Achieve		Avoid	
Positive Influences	Negative Influences	Positive Influences	Negative Influences

1. My best friend
2. Other friends — what they do and what they think of me
3. My parents — the example they set and what they expect of me
4. Someone older (famous or not) whom I admire.
5. Messages I receive from the media — TV, magazines, news, movies, etc.

51604 6062



# FREE INSIDE!



.....➔  
***Educational program to help students:***

*strengthen their refusal skills.*

*learn to accept responsibility for their decisions.*

*grow in self-confidence and self-worth.*

51604 6063

*Verne* 35  
3-22-97

**the pressure**

**Take A  
STAND**

**WARN ABOUT THE  
CONSEQUENCES**

**WALK  
AWAY**

**Steer  
Clear**

Peer refusal skills play an important part in your students' lives. As young people become less dependent on parents, it is natural for them to turn to their peers for information, advice and reassurance that they are okay. Unfortunately, this reliance on peers often interferes with the individual's ability to make important decisions.

A young person may find it increasingly difficult to resist peer pressure and influence, sometimes going along with the crowd automatically, even when this leads to choices the individual knows are wrong for him or her. For some, getting into trouble seems preferable to the risk of losing a friend. Stephen E. Gardner of the National Institute on Drug Abuse concludes that the pressure and influence of peers is "almost always involved in the problem behaviors" of adolescents.

This study guide, part of the RIGHT DECISIONS, RIGHT NOW program, is designed to help students deal more effectively with negative peer pressure and influence. The RIGHT DECISIONS, RIGHT NOW program is funded by the R.J. Reynolds Tobacco Company, which firmly believes that children should not smoke. Young people need to recognize that, while peer pressure often renders decision making more difficult, they can learn to cope with that pressure.

Developed for use with students in grades 6-9, the activities and teaching suggestions in this guide will help students strengthen their refusal skills. They will examine their right to resist peer pressure, analyze ways in which their decisions can have consequences for others and apply different strategies for saying No in a variety of situations.

We encourage you to share this exciting program with your colleagues. Although the materials are copyrighted, you have permission to make as many copies as you need for educational purposes.

Please take a moment to complete and return the enclosed response card. Your comments will help us to create programs that continue to meet your needs. Returning this card also ensures your continued receipt of free educational programs.

Enjoy watching your students gain in confidence and self-esteem as they complete the activities in this program and strengthen their capacity to make the right decisions right now.

Sincerely,



Dr. Dominic Kinsley  
Editor in Chief

51604 6064

**RIGHT  
DECISIONS  
RIGHT  
NOW**

**LIFETIME LEARNING SYSTEMS, INC.**  
... an Experience in Dynamic Education

79 Sanford St. Fairfield, CT 06430 (203) 259-5257

## INTRODUCTION

This study guide, the third in the **RIGHT DECISIONS, RIGHT NOW** program, is part of a continuing effort to help students develop sound decision-making skills. The earlier two guides were designed to help students understand the decision-making process and to analyze the immediate and the long-range consequences of the choices they make. This study guide focuses more directly on developing students' capacities for resisting peer pressure.

Normally, an individual makes decisions based on his or her own private, internal system of values. Unfortunately, young people often allow this value system to become skewed by the overriding importance placed on having — and keeping — friends. All too often, the exaggerated value placed on even the illusion of friendship short-circuits the individual's decision-making process. He or she gives in to the pressure and may even feel powerless to act in any other way.

Students themselves are keenly aware of the power of negative peer pressure. In the 1992 *Weekly Reader* Survey on Drugs and Drinking, the vast majority of middle-grade students said that the most important reason for using illegal substances is to "fit in with others." By grade six, more than 50 percent of the students report that peers have pressured them to drink beer or wine; more than 30 percent have felt pressure to use marijuana or crack; and nearly 60 percent have been pressured to smoke cigarettes.

This study guide has been developed to help students deal more effectively with these negative pressures. Through its four activities, students will rate the difficulty of saying No to their peers in specific situations and discuss different ways they might say No.

They will also consider the responsibility that comes with making decisions by weighing the consequences of choices not only for the decision maker but also for family members, peers and the law.

## INTENDED AUDIENCE

**RIGHT DECISIONS, RIGHT NOW** is designed for use with students in grades 6-9. It can be incorporated into social studies, health and life skills courses, or any subject area in which decision making is taught.

## PROGRAM OBJECTIVES

- To help students understand that saying No can be difficult but they do have the right to say No.
- To teach students ways to say No and to apply them in specific situations.
- To provide a forum in which students can talk about their values and concerns.
- To help students recognize the values that guide them and establish what is most important to them in making decisions.
- To help students understand the need to accept responsibility for their decisions and actions.
- To encourage students to analyze the consequences of their decisions in relation to their family, their peers and the law.
- To help students develop a greater degree of self-confidence and self-worth.
- To provide an opportunity for students to practice applying their refusal skills in a wide variety of situations.

## PROGRAM COMPONENTS

1. Four Activity Masters to reproduce as worksheets for each student.

2. This Teacher's Guide which includes:
  - background information.
  - suggestions for introducing each activity.
  - ideas for extending each activity.
  - a list of resources for teachers.
3. A full-color poster that highlights the program's concepts.
4. A teacher response card for your comments about the program. Returning this card ensures that you will receive future free educational programs.

## USING THE PROGRAM COMPONENTS

### Activity Masters

Use a photocopier or other school equipment to make copies of each Activity Master to serve as individual worksheets for students. The activities are presented in an effective learning sequence, but you may wish to change the sequence to meet the needs of your students.

As with the other materials in the **RIGHT DECISIONS, RIGHT NOW** program, it's important to establish an atmosphere of frank and open discussion. Students should see the activities as an opportunity to work together on issues that concern them rather than a test situation in which the teacher is looking for the "right" answer. Explain to students that the activities will give them the opportunity to look more closely at how peer pressure operates and how they can keep that pressure from dictating their decisions.

### Poster

Display the poster in a prominent place in the classroom. Draw students' attention to the catch phrases they can use when saying No. Encourage them to refer to it often as a reminder of different ways they might say No when they find themselves in difficult situations.

## ACTIVITY ONE

# SAYING NO—EASY OR HARD?

### **Objective**

To help students understand that saying No can be difficult but they have the right to say No.

### **Introduction**

Ask students to think about a situation in which friends want them to do something they know is wrong. Choose a situation that is relevant to your students' current concerns — smoking, cheating, stealing — anything that seems likely to strike a responsive chord. Discuss with them why it might be difficult to resist friends in this particular case. Use the discussion as a springboard to talk about why it's sometimes difficult to resist the pressure your friends place on you. Help students see that the fear of losing friends, or the desire to feel liked and approved, can lead a person to make a decision he or she knows is wrong.

## **PART I**

### **Presentation**

Have students complete this portion of the activity independently. Before they begin, be sure students understand that they have a "right" to say No when someone pressures them to do something they feel is wrong, and that this exercise will help them learn how difficult saying No might be for them.

As students read the situations on the activity sheet, encourage them to imagine that they are in each one described. They should rate on a scale of 1-5, with 5 being the most difficult, how easy or hard it would be for them to say No in each situation.

### **Discussion**

The activity should help students recognize a very real and complex conflict — they want to make decisions that are right for themselves, but this may conflict with what their friends want them to do, making the right decision more difficult. It is helpful to point out that adults face the same types of conflicts. For example, a friend who has a drug problem asks to borrow some money for food — the person wants to help out but is afraid the friend will use the money to buy drugs instead of food. Students should recognize that conflicts like these are normal, and that part of growing up is learning to make the right decision even when your friends want you to do something else.

Another important point to develop is that peer pressure can operate in positive ways. Challenge students to try to reverse some of the situations — looking for ways that positive peer pressure could lead to the right decision.

## **PART II**

### **Presentation**

Divide the class into groups to complete this portion of the activity. Encourage students to be as candid as possible in their responses. The important goal here is to have them consider how they feel about themselves when they say No — or when they yield to peer pressure.

### **Discussion**

Ask volunteers to share their responses. In discussing these responses, it will be

helpful for you to model supportive comments rather than challenge a student's real or hypothetical rating and feelings about that rating. This will help the rest of the class feel more willing to risk talking about their experiences. Student responses should help you draw out the idea that when people make the decision that's right for them, they feel better about themselves. The class might also recognize that they rarely lose friends by making the right decision and they may even find that friends treat them with a new respect for having stood their ground.

### **Extending the Activity**

1. Divide the class into their small groups to talk about difficulty in saying No in specific situations. Encourage students to see if there seems to be a commonality in situations that prove difficult. Then meet as a class to concentrate on identifying difficult situations for your students. You can concentrate on these areas throughout the program.
2. Have students watch their favorite TV sitcoms to look for incidents in which the characters either caved in to or managed to resist pressure. In discussing the episodes in class, focus on (1) how difficult it was for the person to make the decision; (2) how the person felt about his/her decision; (3) how realistic students thought the situation was.

## ACTIVITY TWO

# WAYS TO SAY NO

### **Objective**

To teach students ways to say No and to apply them in specific situations.

### **Introduction**

Describe a specific situation in which saying No is clearly the right decision. The topic can be anything that seems appropriate for this group of students — cheating, stealing, smoking, drinking, vandalism. Ask volunteers to tell how they would say No in that situation. To make the feeling of peer pressure more realistic, you might even have several pairs or groups of students role play the incident. Use this introduction to draw out the idea that there are different ways to say No. Much depends on the situation, the individuals involved and the kind of pressure that is being applied.

### **PART I**

#### **Presentation**

Allow students as much time as they need to complete the activity sheet for Part I. Encourage them to think about each refusal method in terms of a specific situation in which they might be feeling pressure. You can use situations from Activity One, suggest a new situation or have the students create their own.

#### **Discussion**

After students have completed the activity sheet, discuss each of the ten methods, asking volunteers to explain when and why they think a particular method would be useful. Use the following questions as a guide to discussion:

1. What do you think you might actually say in using a particular method?
2. Are some ways to say No better for certain situations? For example, if a group of kids pressures you to try sniffing paint thinner, would you use the same method as you would in a situation where a best friend wants you to lie for him or her?
3. Are there some ways to say No that wouldn't work for you? Which ones? Why?
4. Can you think of any other ways to say No that aren't on the activity sheet? What are they?

### **PART II**

#### **Presentation**

This portion of the activity offers an opportunity to use role playing to provide students with a more vivid sense of what peer pressure feels like. Assign different groups of students to prepare a brief skit for each of the situations; or, you may want to alter the situations or create new ones to focus more directly on the concerns of your students.

Encourage students who are acting out the scenes to be realistic in the ways they apply pressure. They should also be advised to keep it simple — one or two sentences is enough to simulate the kind of pressure needed.

#### **Discussion**

As each situation is acted out, discuss the results with the class. Use the following questions as a guide:

1. Which of the ten ways to say No was used?
2. Did the method used work? If not, what do you think went wrong?
3. Can you think of other ways to say No that would have been better in this situation?

#### **Extending the Activity**

1. Divide the class into four or five groups. Have each group brainstorm ways in which students can help each other resist negative peer pressure. For example, how can a group of students work together to strengthen their refusal skills?
2. Have students interview older family members, asking them about situations in their teens when they had to resist peer pressure in order to make the right decision. This process can strengthen communication among family members while providing students with new ideas about refusal skills.

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## ACTIVITY THREE

# IT'S YOUR RESPONSIBILITY

### **Objective**

To help students understand the need to accept responsibility for their decisions and actions.

### **Introduction**

Briefly review the mental steps involved in making a decision:

- Step 1: Conflict — why do you have to make a decision?
- Step 2: Goal — what do you want to have happen?
- Step 3: Alternatives — what choices do you have?
- Step 4: Consequences — what good or bad things can happen with each choice?
- Step 5: Decision — making your choice.
- Step 6: Reflection — how do you feel about your decision?

Explain that this activity focuses on two of the steps — the conflict and the consequences. Many decisions young people face involve a conflict between doing what they think is right for themselves and doing what their friends want them to do. In other words, peer pressure creates a conflict of values — friendship vs. things that are important to them (honesty, avoiding drugs, etc.).

Thinking about the consequences of a decision is one of the best ways to resolve the conflict. The consequences can often involve more than the decision maker; there are likely to be consequences involving family members, friends and sometimes even the law.

### **Presentation**

Divide the class into six small groups to work on the three scenarios.

Have half the groups fill out the consequences chart on the assumption that James, Mark and Jody each give in to peer pressure; the other groups should assume that the three individuals resist the pressure. In both cases, students should use their collective imagination to consider the possible consequences.

### **Discussion**

When all groups have completed their charts, ask a spokesperson for each group to report its findings. Point out any difference in the reports that assume resistance to peer pressure and then in the reports that assume giving in to the pressure. Notice if any groups deal with how James, Mark and Jody feel about themselves once they've made a decision. Come back to this later as one of the major consequences to consider in making any decision. In discussing the ideas the groups have developed, you can draw out such points as:

1. Both James and Jody risk legal consequences if they give in to peer pressure; their friends are asking them to break the law. Mark is being asked to break rules.
2. All three situations can involve long-range consequences such as a criminal record or perhaps long-term strained relations with friends and/or family members.
3. By saying No, James, Mark and Jody risk the anger or disapproval of their friends. In fact, for Mark to report the knife to school authorities will require moral courage and might easily

end a friendship. Ask the class how Mark might deal with the situation by applying positive peer pressure. You can expand on this idea by having the class consider what kinds of situations might lead them to sacrifice a friendship in order to protect their own sense of self-worth or self-respect.

### **Extending the Activity**

1. Have students write an entry for a journal or diary describing an older person they feel they could talk to about a difficult decision. This could be a parent, an older sibling, a teacher or coach, a family friend, etc. Encourage students to write about the qualities this person possesses that would make him or her someone to turn to.
2. Divide the class into small groups to brainstorm situations in which there is a conflict between friendship and doing what a person feels is right. The groups can then exchange situations to discuss ways of handling each situation and measuring the consequences.



## ACTIVITY FOUR

# PRACTICE MAKING DECISIONS

### Objective

To provide an opportunity for students to practice applying their refusal skills.

### Introduction

Spend a few minutes reviewing the concepts the students have learned — their right to say No, different ways to say No and measuring the possible consequences of each decision.

### Presentation

Divide the class into four groups, assigning one situation to each group. Each group should discuss ways to deal with the assigned situation and consider the possible consequences. The groups can either report their solutions to the class or present them as skits.

### Discussion

When all groups have finished, use the following questions and ideas to guide discussion:

1. Were there other ways to handle any of the situations that might have been as effective or even more effective?
2. What ways to say No were used in each case?
3. Point out that all four situations center on a conflict involving friendship. How difficult did this make the decision? What do the students think will happen to the friendship in each of these cases? You can use this last point to raise the question of the qualities a friend should have. Encourage the class to make a list of qualities that completes the statement, "A friend is someone who ...". Conclude the discussion by asking students if there are occasions when it might be important to reconsider who they want as friends.

### Extending the Activity

1. Extend the discussion of the conflict between friendship and other personal values by asking students what decision they would make in certain situations. For example, suppose some friends have cheated on a test and the teacher asks you about it. Or, there's an incident on a school bus and you know who is at fault. Should you report it or protect the friend? Is there another choice that might be better than either of those alternatives?
2. A small group of students can start an advice column, either for the class or for the school newspaper. Students can then write to "Dear Advice" for help with difficult decisions. Letters and advice, of course, should have adequate faculty supervision.

### Resources for Teachers

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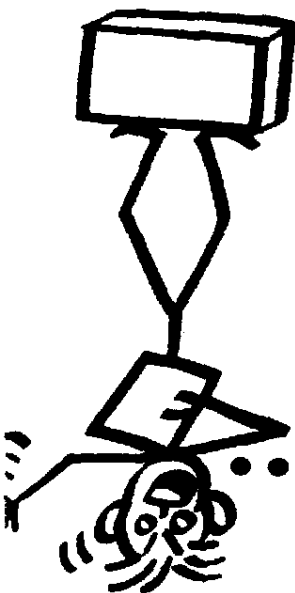
WHY NOT TALK ABOUT THE



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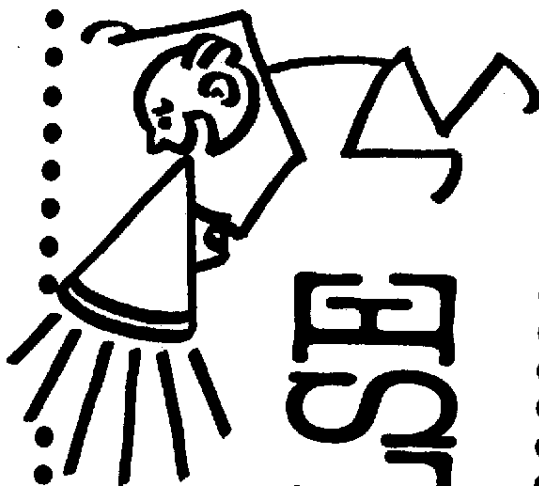
1 Take A Stand



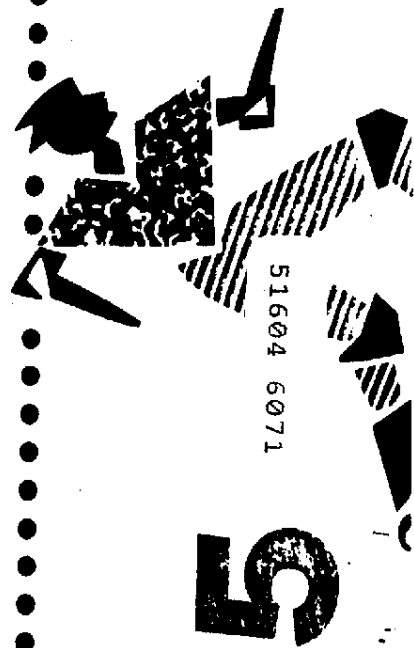
Why  
ON TO SAY

WHEELS

3  
ADD A LITTLE  
HUMOR



4  
SUGGEST  
SOMETHING ELSE



5  
Steer clear

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6

**REVERSE**  
the pressure

7

***Walk away***

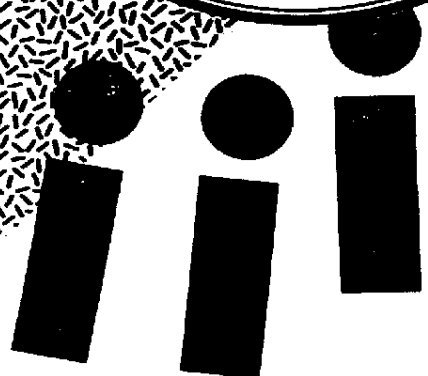


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**ASK A  
QUESTION**



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10



6

# WAYS TO SAY NO



There are many ways to say No. Choosing the best way depends on the type of situation you're in and what feels right to you. By thinking about how you might say No in different situations, you'll be better prepared for getting out of those tough spots.

**PART I** Some effective ways to say No are described here. Each way includes one or two examples of what you might say. Read each statement carefully and put a check mark next to the ones you think might work for you.

	WAYS TO SAY NO	YOU MIGHT SAY
1.	Take a stand, and stick up for yourself.	"I don't want to do that. It's not good for me."
2.	Say No, and warn about the consequences.	"We could get hurt." "We could be expelled."
3.	Say No, but try to add a little humor to your refusal.	"That's like having a tooth pulled." "I'd rather be a chicken than have my goose cooked."
4.	Say No, and change the subject or suggest something else.	"What did you think about (TV show, movie, event)?" "Let's go work out instead. It's a better challenge."
5.	Avoid the pressure.	You won't have to say anything if you stay away from people or situations that can put you on the spot.
6.	Put on a little pressure of your own.	"Hey, you know that's bad for you. Don't put yourself down like that." "I thought you were my friend; a friend wouldn't ask that."
7.	Say No, and walk away with no explanation.	"No."
8.	Say No and ask a question.	"Why would I want to do that?" "Have you thought about what will happen if we do this?"
9.	Make an excuse, even if you have to stretch the facts a little.	"I can't. I promised my mother I'd go shopping for her." "I have to go home and study for a big test tomorrow."
10.	Say No, and give a reason for your refusal.	"It's against the law." "I'd be grounded."

**PART II** Now that you know some ways to get out of tough spots, try them out. Which approach would you use in each of the following situations? Write down what you would say and give your reasons for choosing that approach.

1. You are out with a couple of friends who smoke, and they offer you a cigarette. They say it is time for you to stop being a wimp and start smoking like them.

What would you say? \_\_\_\_\_

Reasons: \_\_\_\_\_

2. An older student offers you ten dollars to deliver a package and warns you not to ask any questions.

What would you say? \_\_\_\_\_

Reasons: \_\_\_\_\_

3. You're at a school dance and some of your friends have a bottle of wine. They pressure you to have some with them.

What would you say? \_\_\_\_\_

Reasons: \_\_\_\_\_

4. Some of your friends plan to steal a CD at the mall and they want you to distract the salesperson by asking questions.

What would you say? \_\_\_\_\_

Reasons: \_\_\_\_\_

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## IT'S YOUR RESPONSIBILITY



You know that all decisions have consequences — good or bad, immediate or long-range. Some of the decisions you make can also have consequences for others — members of your family, your friends, even the law. Thinking about all the possible consequences is one of the hardest parts of making a decision, but it's also one of the most important.

### PART I

In the situations described below, students have to make tough decisions. Work with your assigned group to figure out what the consequences might be for each of the decisions listed.

- A** James is with some friends one night and they visit Charles, an older guy James has seen around school but doesn't know. The friends buy some marijuana from Charles and pressure James to buy some and try it. They say things like, "Come on, man. We all smoke it. Don't be such a little kid."
- B** Mark's best friend says, "Look, I brought this switchblade to school today. If that bully Carl picks on me, he's going to get a big surprise. Don't tell anyone I have it. You're the only one who knows."
- C** Jody sees some friends in the parking lot long after school hours. They have some crack and invite her to share it with them. Jody hesitates so they begin to pressure her. They say things like, "Come on, Jody, no one's around. What are you scared of? Are you part of our group or not?"

		Consequences For			
Decision Made		Decision Maker	Friends	Family Members	The Law
<b>JAMES</b>	<i>Buys some pot and smokes it</i>				
	<i>Refuses</i>				
	<i>Refuses and reports to school that Charles is a dealer</i>				
<b>MARK</b>	<i>Keeps friend's secret</i>				
	<i>Refuses and reports to teacher</i>				
<b>JODY</b>	<i>Gives in to pressure and tries crack</i>				
	<i>Says No and gives reason</i>				

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### PART II

Brainstorm with your group about the decision that would be best for James, Mark and Jody. Report your conclusions and reasons for them to the class.



## ACTIVITY FOUR

# PRACTICE MAKING DECISIONS

**RIGHT  
DECISIONS  
RIGHT  
NOW**

In each of the situations below, it might not be easy to say No. Work with your group to decide on the best way to handle the situation assigned to you. Before you begin the discussion, write down some options that might be considered. After brainstorming the options and selecting one, you might want to try turning the scene into a skit and acting it out for the class.

### Situation 1

You studied hard for a big test. As you enter the classroom, your best friend whispers to you, "I didn't have time to study last night. Let me copy your answers or I'll flunk for sure."

Options:

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### Situation 2

All of your friends are pushing you to go with them to a party where the parents aren't home. You'd like to go and you're afraid these friends might drop you if you refuse. But you've heard some tough kids are going to crash the party and you don't want to get mixed up with that. Besides, your parents would be furious if they found out you went.

Options:

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### Situation 3

You went to a baseball game with your best friend and his uncle. It's time to go home, but your friend's uncle has been drinking at the game and you're concerned about riding in his car. Your friend becomes annoyed and says, "Don't be such a sissy. He's only been drinking beer and he can handle it."

Options:

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### Situation 4

Your next-door neighbor, who is also a good friend, is sick so he isn't going to school. He offers you \$25 if you will deliver some drugs for him. He tells you he'll be in big trouble if you don't help him. You don't want your friend to get hurt, but you don't want to get involved in anything illegal.

Options:

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## ACTIVITY ONE

# SAYING NO—EASY OR HARD?



Sometimes it's easy to say No. Other times it's hard to do. But you do have the right to say No...to refuse to do something your peers want you to do if you feel uncomfortable about it...to say No to a friend whenever that friend pressures you to do something that you feel is wrong.

How many times have you done something you didn't want to do just because your friends pressured you? Have you ever done something you felt was wrong simply because it was hard to say No?

### PART I

The situations listed here show some kinds of pressures you might face. After reading each one, rate it on a scale of 1-5 (with 1 being easy and 5 hard) on how easy or hard it would be to say No.

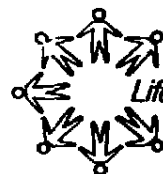
1      2      3      4      5

1. My peers have some beer and keep bugging me to just try some.
2. The group of kids I want to hang out with tells me I have to shoplift something at the mall first.
3. Several of my friends smoke, and they are trying to get me to smoke to be like them.
4. My friends want me to drop the new girl because they say she's a snob.
5. My best friend asks me to steal a pack of cigarettes from my mom's purse.
6. One of my friends wants to hide some rocks of crack in my room until his mother goes to work.
7. A friend of mine took part in smashing a store window and taking a CD player. Now he wants me to say he was with me if the police ask.
8. My friends want me to use the money I found laying on the floor at school to buy pizza, but I want to turn it in to the office.
9. Some of my classmates have a copy of the math exam and are pressuring me to help them work out the answers.
10. My best friend asks me to cover for her by saying she was at my house when she sneaked out with a guy.

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### PART II

Meet with the group to which your teacher assigns you to share some of your experiences. Tell about a situation in which you wanted to refuse to do something. Include your feelings and actions. Why did you want to refuse? Did you refuse? How difficult was it to say No? What caused you to make the decision you did? How did you feel about the decision?



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# FREE INSIDE!

## **Educational Program To Help Students:**

- ▶ define and rank specific values.
- ▶ learn how values guide decisions.
- ▶ strengthen reasoning skills.



Verner 36  
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51604 6078

# Dear Educator

Studies of adolescent behavior show that young people can generally distinguish right from wrong, but that they frequently don't act on this knowledge. When asked, they can usually give the "right" answer but, when faced with an actual situation, they frequently choose a "real" response reflecting a different set of values. Teens know it is wrong to steal or cheat, for example. Yet, according to the Josephson Institute of Ethics Survey, 33 percent of high school students say they have stolen something and 61 percent say they have cheated on a test.

Schools can help early teens close the gap between their perception of what is "right" and what is "real." In fact, as Robert McClure of the National Education Association states, "schools may be the only place a lot of youngsters are given an opportunity to learn such traits as honesty and kindness."

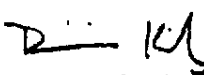
This study guide, the fourth unit of the RIGHT DECISIONS, RIGHT NOW program, is designed to help your students examine the framework of beliefs and personal values that guides the decisions they make and to help them discover ways of strengthening that framework. The first three units of the program dealt with the decision-making process, resisting peer pressure or peer influence and improving refusal skills.

The RIGHT DECISIONS, RIGHT NOW program is funded by the R.J. Reynolds Tobacco Company, which firmly believes that children should not smoke. The program, created for use with students in grades 6-9, is designed to help them become more effective decision makers.

Please take a moment to complete and return the enclosed response card. Your comments help us to create programs that will continue to meet your needs. Returning this card also ensures your continued receipt of free educational programs.

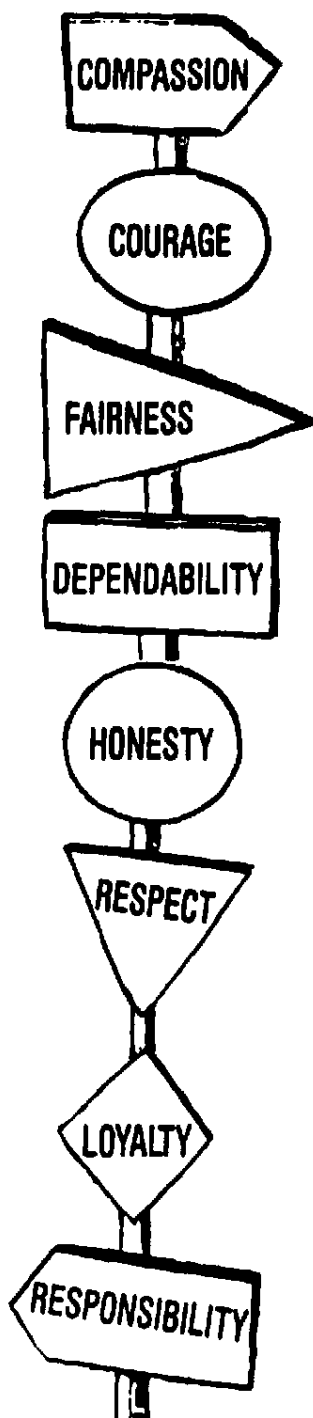
We hope you enjoy completing this program with your students and watching them grow in confidence as they learn to make the right decisions, right now.

Sincerely,

  
Dr. Dominic Kinsley  
Editor in Chief

79 Sanford St. • Fairfield, CT 06430 • (203) 259-5257

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## INTRODUCTION

This study guide is the fourth unit of the **RIGHT DECISIONS, RIGHT NOW** program. The activities and teaching suggestions are designed to improve students' decision-making skills by helping them analyze the beliefs and personal values which guide the decisions they make. The research on which the materials are based makes it clear that students are not only willing to talk about moral dilemmas or conflicts in a non-threatening environment, but that such discussions and related activities help them develop a deeper understanding of the decision-making process.

An important first step is to gain a sense of how your students currently perceive some of society's core values, such as honesty and responsibility. Research indicates that young people and their parents often have different ideas of what such value concepts mean. By examining ways in which their perceptions differ from those of their parents, students and their families can avoid a good deal of misunderstanding. At the same time, this process of taking stock will help you recognize where the areas of confusion or inconsistency are in the value frameworks your students have constructed.

This program is designed to provide students with guided experiences in analyzing the role of personal values in decision-making. Students will recognize that underlying all of the complex and difficult decisions they face is a basic conflict of values. Making a decision involves making a choice — deciding that one personal value is more important than another, at least in that particular situation.

For early adolescents, these conflicts often involve making a choice between what the person believes to be right and the demands of friendship. Because friendship is so powerful and pervasive for this age group, we have not treated it as a separate value. Instead, it should be seen as a potent force that can influence or complicate decision making; in fact, many teens operate according to a dual set of values — one set for friends, another for all other relationships. Lying, for example, is perceived as wrong, but lying to protect a friend is not.

Your role is vital in helping students analyze and strengthen the framework of personal values by which they currently live. While it is neither wise nor feasible to dictate codes of conduct, it is important to keep students from adopting a value system in which anything goes as long as friends approve. The goal is to guide them in exploring real-life conflict and helping them to see that a more consistent frame of values will enable them to make more effective and, in the long run, more satisfying decisions.

## INTENDED AUDIENCE

This program has been designed to be used with students in grades 6 - 9. The materials can be incorporated into social studies, health or life skills classes.

## OBJECTIVES

This fourth unit of the **RIGHT DECISIONS, RIGHT NOW** program is designed to help students:

- ▶ work in groups to define certain value concepts and, through discussion, see if they can agree on definitions.
- ▶ determine which values are most important to them.
- ▶ discuss key values with their parents or guardians.
- ▶ recognize that the decisions they make are guided by their personal frameworks of values.
- ▶ examine the values involved in a variety of situations that reflect their real-life concerns.
- ▶ understand that people's words and actions often reveal the values they regard as most important.
- ▶ use role-playing scenarios to understand the thoughts and feelings of both sides in conflict situations.
- ▶ strengthen their capacity for reasoning based on sound values.
- ▶ understand that they can help each other in making and sticking to tough decisions.

## PROGRAM COMPONENTS

1. Four activity masters to reproduce as individual and group worksheets.

2. This teacher's guide which contains:
  - Background information.
  - Suggestions for presenting each activity.
  - Ideas for extending each activity.
  - A list of resources.
3. A full-color poster that encourages students to think about the personal values underlying the decisions they make.
4. A teacher response card that allows you to comment on the program.

## IMPLEMENTING THE PROGRAM

### Classroom Environment

An important element in the success of all the activities is the classroom environment you are able to establish. If students feel they are being judged or evaluated, they will slip into the "right answer" mode, giving responses they think an adult expects. Your own teaching style is the most effective way of assuring the class that this is not a test situation.

### Group Work

The activities are designed for students to work on together in groups of 6-8. You can have students remain in the same group throughout the program or change groups for each activity. Each group will have a group leader and a recorder. These positions should change each time, with the recorder reporting the group's conclusions to the class. Group leaders need to keep the group focused and working. The following rules should be established by the leader prior to any discussion.

1. Members are allowed to pass if they feel uncomfortable with specific topics.
2. No putdowns are allowed.
3. Everyone has to take a turn talking.

### Poster

The poster contains a list of the values that are focused on in this program. Display it in an area where it is easily accessible to students and encourage them to use it for reference purposes.

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# ACTIVITY TWO

## What Would You Do?

### Values focused on:

*honesty, courage*

### OBJECTIVES

- ▶ To help students understand that people's words and actions often reveal the values they regard as most important.
- ▶ To gain experience in analyzing value conflicts involving honesty.

### BACKGROUND

Students sometimes use *honesty* and *truthfulness* interchangeably. Honesty is the broader of the two and encompasses truthfulness; that is, telling the truth is an aspect of being honest.

Students almost always associate *courage* with *physical courage* — risking bodily harm for the sake of some goal. *Personal courage* involves the ability to face a complex moral choice with self-possession, confidence and resolution, and to risk disapproval in order to make a choice one believes is right.

As young people gain experience with this concept and begin to see that personal courage is needed to make the decisions that are right for them, they begin to consider it one of the most important personal values.

### INTRODUCTION

Explain to students that this activity will help them learn how people's personal values determine how they behave. Divide the class into groups, keeping the same groups as in Activity One or rearranging them to change the interaction. New group leaders and recorders should be selected.

### In Your Group

Allow as much time as the groups need to work through both situations, but ask each group to let you know when they have decided what Pat did with the wallet in Situation A. Write the following pieces of information on the chalkboard, assigning one to each group. If you have more than four groups, assign the same information to more than one group. Explain that, in going through the wallet's contents, they have found this information about the owner. They are to decide how this information might change Pat's decision. [Group 1] The wallet was lost by a well-known business owner. [Group 2] The wallet belongs to an elderly widow who planned to use the money for a vacation to visit her grandchildren. [Group 3] The owner of the wallet is a parent of a student in Pat's school; Pat doesn't know the student. [Group 4] The wallet was lost by Pat's best friend's parent.

In Situation B, students will see a similar dynamic operating — the choices may change, depending on Chris' relationship to the others involved. Follow the same procedure as for Situation A. [Group 1] One of the two classmates is Chris' best friend. [Group 2] Chris only knows the two students slightly. [Group 3] One of the students is the toughest kid in the class. [Group 4] Chris doesn't like one of the students involved.

### With The Class

Bring the groups back together to discuss their findings. Before the discussion, take a few minutes to clarify the concepts of honesty and courage. As the group reports and discussion progresses, ask students how *honesty*, *responsibility*, *fairness*, *respect* and *courage* were involved in each situation. While you cannot dictate a change in beliefs, you can look for opportunities to help students see that such concepts as responsibility and respect should extend beyond the immediate circle of friends.

### EXTENDING THE ACTIVITY

1. Explore the concept of personal courage more fully through examples in history, biography and autobiography. John F. Kennedy's *Profiles in Courage* offers good examples, as does the TV series based on the book (available in video cassettes from Zenger Productions).
2. Have students write about incidents in their own lives in which they had to make difficult decisions involving honesty. Ask volunteers to read their accounts to the class or arrange to have a few read aloud without identifying the writer.

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# What Does It Mean?

## Values focused on:

*compassion, courage, dependability, fairness, honesty, loyalty, respect, responsibility*

## OBJECTIVES

- To help students define certain value concepts, and to see if they can agree on definitions.
- To rank these values in order of importance to themselves.
- To encourage students to discuss key values with their parents or guardians.

## BACKGROUND

Since many students confuse the word *value* with *valuable*, be sure that they understand the meaning of the word *value* as used throughout this program. Value, in this case, refers to a personal belief.

Both defining the value words and ranking them in order of perceived importance often leads to extended discussion and debate. It is frequently an eye-opening experience for students to discover that their peers share their uncertainties about figuring out what they think is right or most important, especially when specific types of conflict are mentioned.

## INTRODUCTION

A useful step for establishing a productive atmosphere is to introduce this activity with an actual "values" conflict involving a topic the students care about. This might be a current headline of a real-life incident that emerges in your community or an episode within your school. Encourage students to talk about it, focusing on the reasons for people's actions.

## On Your Own

Instruct students to work individually to complete Part I of the activity. Make sure they understand that they should write what the words mean to them, rather than striving for a dictionary-type definition. Remind students to rank the values (personal beliefs) in order of importance to themselves.

## In Your Group

For Part II of the activity, divide the class into groups, with a group leader and a recorder in each one. You can appoint these positions or have groups select their own. Encourage groups to work independently on this section, but let group leaders know that you are available for consultation if necessary.

## With The Class

Once the groups have completed Part II of the activity, bring the class together and ask the recorders to report the findings of their groups. Focus first on the definitions, then on the rankings. Encourage discussion of the differences that emerge and see if the full class can come to a general agreement.

More mature students may recognize that both the definitions and the rankings are likely to depend on the context. Loyalty, for example, is a concept that is not well understood at this age level and is usually not ranked highly. Some students may realize, however, that in a situation involving a best friend, loyalty to that friend may jump to the top of the list.

To complete the discussion of Part II, ask the students to tell how they think their parents' or guardians' definitions of values might differ from theirs.

All groups should keep track of their responses to Activity One. After the class has worked through some specific situations in the next two activities, you will be asking them to redefine these values and compare them to the originals to see if their thoughts have changed.

## EXTENDING THE ACTIVITY

1. Encourage students to talk about values with their parents or guardians. Students should bring their findings back to discuss in general terms with their groups and the class.
2. Working within their groups, ask students to think of stories, novels or biographies they have read recently. Each group should make a list of the main characters in these works and, next to each name, give an example of how one of the eight values was important to the person's life or in the story. If students need help, you might refer them to various *Aesop's Fables*. In "The Lion and the Mouse," for example, the mouse feels *compassion* for the lion.

# What's At Stake?

## Values focused on:

*compassion, honesty, loyalty, respect, responsibility*

## OBJECTIVES

- ▶ To help students understand that friends can make tough decisions easier or harder for them.
- ▶ To help students recognize ways they can help their friends in the decision-making process.
- ▶ To encourage students to respect each other's decisions and to support each other in making and sticking to decisions.

## BACKGROUND

Friendship is of prime importance to adolescents, so much so that it can be the determining factor in many of the decisions that they make. The values that adolescents live by are in great part regulated by the level of friendship. For example, young people would be willing to tell on someone if they did not know that person, but would lie if that person were a friend. Thus, working within the context of friendship, students can learn how their values can make decisions easy or difficult for others.

## INTRODUCTION

Initiate a discussion about friends and how often they share confidences. Elicit from students that some of these things they talk over are simple — what to wear, which film to see, who the best recording artist is. But some things, especially if they involve tough decisions such as whether or not to drink, smoke or carry a weapon, can get complicated. As you divide the class into groups, let them know that they will be exploring ways they can help each other in those tough spots.

## In Your Group

In working through the situations, the groups are likely to find that several actions can be taken. First, they should identify the dilemma involved with each decision. In Situation 1, Latanya faces a conflict between honesty (being truthful to her friends) and loyalty (being different from the group). In Situation 2, Shaun has to deal with the conflict of loyalty to a friend and a sense of responsibility. In both situations, however, personal courage plays a part.

Once the conflicts have been identified, students should focus on how they can help make the decision easier or harder for the person.

## With The Class

As the groups report their conclusions to the class, ask them how the values of *responsibility, honesty, respect* and *personal courage* were involved in their recommendations of how friends might make decisions easier or harder for their friends.

## EXTENDING THE ACTIVITY

1. One way to encourage students to talk to each other about tough decisions is to have them meet in small groups, according to the type of conflict they are facing. Have students write on a slip of paper, the type of conflict they would like to talk about — smoking, drinking, stealing, telling on a friend. Then have students meet in the appropriate groups to talk about situations and how they can help each other.
2. Arrange a round of Group Challenges. Have the groups exchange situations that they discussed in their group

work and challenge the groups they exchange with to come up with ways friends might help each other.

## RESOURCES FOR TEACHERS

- William J. Bennett, *The Book of Virtues*, Simon & Schuster, New York, 1993.
- The Encyclopedia of Ethical Behavior*, NY, Rosen Publishing Co., 1991.
- L.D. Johnson, *Monitoring the Future: A Continuing Study of the Lifestyles and Values of Youth*, Ann Arbor, MI, Institute for Social Research, 1992.
- Thomas Lickona, *Educating for Character. How Our Schools Can Teach Respect and Responsibility*, NY, Bantam Books, 1992.
- Susan Neiburg Terkel, *Ethics*, NY, Lodestar Books, 1992.
- Video: *Coming of Age* (in Spanish and English), Washington, D.C., The National Coalition of Hispanic Health & Human Services (COSSMHO), 1990.
- Video: *Do Unto Others* (The Ethics of Responsibility), Washington, D.C., Annenberg/Corporation for Public Broadcasting, 1989.

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# Dealing With Conflict

Value focused on:  
*respect*

## OBJECTIVES

- To help students better understand the thoughts and feelings of both sides in a conflict situation.
- To help students recognize and practice ways to use their values to mediate conflict situations.

## BACKGROUND

Role playing conflict situations can give students a clearer understanding of both sides of the conflict. As students work through a scene the first time, both parties are likely to be quite insistent about their positions. When the roles are reversed, however, the actors almost always find it much easier to compromise their positions. Students often express surprise at the experience of "feeling" the conflict from an opposite point of view; some may find they feel a sense of respect for the rights or property of others involved in the scenarios.

## INTRODUCTION

Make students aware of conflict situations by asking them to describe situations in which they feel there is a conflict — a fight with friends, a disagreement with parents, issues in the news. Stress the point that every conflict has two points of view.

## In Your Group

Divide the class into groups, each with a new group leader and recorder. Let students know that the exercise they are about to do will help them better understand the two sides of conflicts. Explain that they will first work in pairs, role playing situations and discussing what they learned.

## With The Class

Bring all of the groups together to debrief the role playing, discussing the students' perceptions of what happened and how switching roles altered feelings.

Point out that the activity involves the concept of *respect* in two ways:

- Respect for the rights and feelings of another — the right of the friends to gather and the rights and feelings of the manager in how he wishes to run his restaurant; the right of the student who stutters to attend school without being ridiculed as well as the feelings of that student; the feelings of the friend who borrows the sweat shirt for prestige and the other friend's feelings about betrayal. In all three cases, developing a sense of respect for the other involves being able to feel what the other person feels.
- Respect for someone else's property. This is often a difficult concept for students to accept. Early teens tend to feel that each person is responsible for his/her own property. A person who loses a wallet, for example, has not been responsible and some students will conclude that this makes it all right for someone else to take the wallet. When a student leaves a sweat shirt in a shared locker, however, a level of complication is added. If students can express some sense of respect for the friend's property (sweat shirt), they should be able to extend this concept to consider their responsibility to the larger community.

## EXTENDING THE ACTIVITY

1. To examine how respect can reduce tensions and help to ease a conflict

situation, have students look for examples in the literature they are currently reading or in a favorite book. Students should write a brief description of the conflict and how one or more characters came to feel a sense of respect for an antagonist. (Many novels about coming of age will present this as a central theme.) Share the reports in class.

2. TV dramas, films and situation comedies are good sources for examining respect and how it is involved in conflict resolution. Have groups select a TV show they feel represents many conflicts and watch a specific episode. Then the group should meet to discuss the conflict, including the points of view for both sides, how it was resolved (or not resolved) and whether the approach was the best it could be.

## RE-EVALUATE THE VALUES

Now that students have had an opportunity to examine their values in detail, have them complete Part I of Activity One in which they define and rank specific values again. Once completed, have students compare their new definitions to their originals. Have any of them changed? In what way?



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# What Does It Mean?

People often think they are talking about the same thing, but they really aren't – especially when they talk about values. When you say "that's not fair," you probably think that everyone knows what you mean. Right? Wrong!

## Part One On Your Own

Find out for yourself. First, tell what these eight values mean to you. For each one, give a definition, a description or an example. Then number them to show how important you think each one is: #1 is at the top, #8 the bottom. Then meet with your group and compare opinions. You'll probably be surprised.

compassion

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courage

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## Part Two In Your Group

**Group Leader:** Get your group together to talk about the members' definitions and rankings. Which value rated number one? Which was at the bottom? Then compare the definitions of individual values. Work to see if the group can reach a general agreement about what each one means.

**Recorder:** Once the group completes the discussion of what each value means, write the meaning in the appropriate space on a blank worksheet or on an index card.

**Group Leader:** After the group has discussed all eight values, do a group ranking. Remember, one is at the top; eight at the bottom. Then talk about how you think your parents would probably rank each value.

# What Would You Do?

When you were younger, you were told to always tell the truth, so you did. But as you got older you were told not to be a tattletale. What were you supposed to do — tell the truth or keep quiet? You're probably still facing confusing situations, where beliefs and rules seem to be at odds. How do you decide which one to follow? Work with your group to try to figure out what's going on.

## In Your Group

**Group Leader:** Call your group together to talk about the situations below — one at a time. Give group members time to read each situation and make notes for discussion. Encourage everyone to tell what they think might affect the person's decision.

**Recorder:** List the options group members give for each situation. Also record their opinions about what should be done and what was probably really done.

**Group Leader:** The group might not agree on what they think Pat or Chris should or would do. If they disagree, take a vote to see which opinion seems to be the most common.

**Recorder:** Record the votes and compare them with other groups when the class meets.

**Group Leader:** Talk with your group about which of the eight values from Activity One were involved in making decisions in these situations. (Refer to poster.)

### Situation A

Pat finds a wallet on the bus. There's \$250 in it along with three credit cards. In addition, there is a driver's license with the owner's home address and a business card that includes the owner's work phone number.

1. What could Pat do with the wallet? List as many options as you can.

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2. What *should* Pat do with the wallet?
3. What do you think Pat *really* did with the wallet?
4. Which of the eight values were involved in deciding what to do?

### Situation B

Chris knows that two classmates who have been ranking on each other plan to have it out after school. It is likely that real trouble could develop because both of them have knives. And kids are starting to take sides. A teacher has heard rumors about the planned fight and asks Chris if it is true.

1. What could Chris do? List as many options as you can.

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2. What *should* Chris do?
3. What do you think Chris *really* did?
4. Which of the eight values were involved in deciding what to do?

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# Dealing With Conflict

When was the last time you were in a conflict situation? Who were you dealing with? How did you feel? How did you deal with it? On this sheet are three situations that have the makings of a conflict. Meet with your group to talk about ways to deal with each one.

## In Your Group

**Group Leader:** Pass out copies of this activity to group members. Then pair off members of your group and assign each pair a situation below to role play.

- ▶ Have each pair of students decide which character they will play. Also allow them time to take some notes on points they would like to bring out in the role play. They can use the back of this sheet for their notes.
- ▶ Help the students taking part in the role play understand both characters better by switching roles during the role play. Once pairs get into the role playing, say "stop" and have them switch roles and continue the role play.
- ▶ Keep the role plays short. Allow three or four minutes for pairs to resolve their conflicts. Then stop the action, even if they haven't resolved the conflict.
- ▶ Talk about what went on in the role play. Use the following questions to get started.
  - How did you feel when you were first involved in the conflict?
  - Did your feelings change when you switched roles?
  - What did you (group) notice when roles were switched? Did feelings and actions seem to change? How?
  - How were fairness, respect, compassion or responsibility involved? Did they help settle the conflict?

**Recorder:** Write down the comments for each of the questions above for each role play. Be sure to keep the notes for each role play separate.

### Situation A

**Setting:** Fast Food Restaurant  
**Characters:** Group of teens; Manager  
**Situation:** A group of teens keeps going to a fast food restaurant where some of their friends work. The manager is upset because the teens are distracting their friends from their work and feels they are turning the restaurant into a hangout. He approaches the teens and asks them to leave.

### Situation B

**Setting:** School  
**Characters:** A group of students that is picking on one student; a student who is observing the action  
**Situation:** One student stutters and is always being made fun of. Usually it's done behind the student's back, but now it is being done right to the student's face. The student looks really hurt. The student who is observing approaches the group.

### Situation C

**Setting:** School  
**Characters:** Student; A second student who is also a friend  
**Situation:** Two friends share a locker at school. One of them has left a "Bulls" sweat shirt in the locker. The friend who shares the locker sees it and would love to wear it to show off. The friend takes the sweat shirt, without asking, and wears it to an after-school soccer game. The sweat shirt ends up being torn. The friend puts it back in the locker and says nothing. In the meantime, the student who owns the sweat shirt finds out what really happened.

# What's At Stake?

Friends are important. You can talk over your problems with them. You can tell them how you really feel. They can help you better understand yourself. And they can help you in those tough spots. Meet with your group to talk about how you can help each other.

## In Your Group

**Group Leader:** Call your group together and ask members to sit in a circle. Talk about the decisions the two kids below have to make. Give everyone a minute to write down how friends might make decisions easier or harder for them.

**Recorder:** List the group's ideas on ways friends can make the decision easier or harder.

**Group Leader:** Have the group make up two more situations in which someone your age has to make a tough decision and talk about how friends can make that decision easier or harder.

**Recorder:** Write down the two situations, the decisions that have to be made and the group's ideas on how friends can make the decision easier or harder.

1. Latanya is with a group of her friends after school. One of them pulls out a pack of cigarettes and passes it around. All Latanya's friends take cigarettes and light up. They expect Latanya to take a cigarette, too. Latanya does not want to smoke, but she doesn't want her friends to think she's a prude either.

**How Friends  
Can Make the Decision Easier**

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**How Friends  
Can Make the Decision Harder**

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2. Shaun's friend has started carrying a gun to school. Shaun is afraid his friend will get in trouble, or worse yet, hurt someone, so he tries to talk his friend out of it, but his friend will not listen. Now Shaun has to decide whether he should report his friend — and risk the friendship — or keep quiet.

**How Friends  
Can Make the Decision Easier**

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**How Friends  
Can Make the Decision Harder**

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# VAULTS

• Guide You In The Right Direction •

COMPASSION

COURAGE

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**FAIRNESS**

**DEPENDABILITY**

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HONESTY

LOYALTY

RESPECT

51604 6091



**RIGHT  
DECISIONS  
RIGHT  
NOW**

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**RESPONSIBILITY**

**Dear Educator:**

Please pass this card along to a colleague in a middle or Junior High school who might be interested in receiving **FREE "Right Decisions, Right Now"** materials. Your colleague only needs to complete and return this card. His or her name will be added to our mailing list to receive future "Right Decisions, Right Now" materials.

Teacher Name: \_\_\_\_\_

School Name: \_\_\_\_\_

School Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Grade(s) taught \_\_\_\_\_ Subject(s) \_\_\_\_\_

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Grade(s) taught \_\_\_\_\_ Subject(s) \_\_\_\_\_

Number of students using these materials \_\_\_\_\_

Number of teachers using these materials \_\_\_\_\_

Your opinion of this program is valuable to us. Please take a moment to comment.

**COMMENTS:** \_\_\_\_\_

\_\_\_\_\_

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☐ **YES, I'm interested in having my students write essays for the RIGHT DECISIONS, RIGHT NOW program.**

RRCVAL3

RDPM-4

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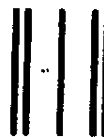
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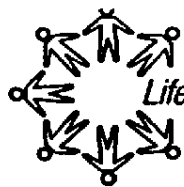
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# **FREE INSIDE!**

***Educational Program To Help Students:***

**RIGHT  
DECISIONS  
RIGHT  
NOW**

- recognize their responsibilities to
  - themselves
  - to their peers
  - to the community
- set responsible goals for themselves
- gain confidence and self-image

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**Lifetime  
Learning  
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*...an Experience  
in Dynamic  
Education*

79 Sanford St.

Fairfield, CT 06430

(203) 259-5257

Dear Educator:

As your students begin making the transition from childhood to adolescence, they face a multitude of changes, one of which is taking responsibility for many aspects of their lives. Yet, if you ask them what responsibility means, they will have a difficult time defining it. This sixth unit of the **RIGHT DECISIONS, RIGHT NOW** program focuses on responsibility – defining it and giving students a solid foundation on which to form their own attitudes and actions.



Too often, young people associate the concept of responsibility with blame ("Who's responsible for this?") or duty ("It's your responsibility to..."). The activities in this program will help your students develop a more positive and proactive sense of responsibility, one that rests on a recognition of their role in a given situation, respect for the rules that apply to the situation and a commitment to their own set of values. Working alone and in groups, they will learn to test their sense of responsibility in the decision-making process, and learn what it means to take responsibility for their actions. In the end, the program should help your students become more self-aware about who they are and what they believe in, and better informed about their responsibilities to themselves and to others.

The **RIGHT DECISIONS, RIGHT NOW** program is funded by the R. J. Reynolds Tobacco Company, which firmly believes that children should not smoke. The program, created for use with students in grades 6-9, is designed to help them become more responsible, committed citizens.

We encourage you to share this exciting program with your colleagues. Although the materials are copyrighted, you have permission to reproduce them for educational purposes.

Please take a moment to complete and return the enclosed response card. Your comments help us create programs that will continue to meet your needs. Returning this card also ensures your continued receipt of free educational programs.

We hope you enjoy completing this program with your students and watching them develop into caring, responsible citizens as they learn to make the right decisions, right now.

Sincerely,

Dr. Dominic Kinsley  
Editor in Chief

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# Teacher's Guide

## RIGHT DECISIONS RIGHT NOW

### Introduction

This study guide is the sixth unit of the RIGHT DECISIONS, RIGHT NOW program. The activities and teaching suggestions are designed to help students understand the meaning of responsibility and learn to take responsibility for their own actions. By instilling a sense of responsibility and commitment in students now, the program can assist you in developing future citizens who will accept and act on their responsibilities to themselves, their families, their community, the workplace and society in general.

### Background

Responsibility can be a nebulous concept for young people, especially as it becomes removed from their immediate life. They will readily and accurately tell you that it is their responsibility to do their homework or take out the trash. Yet they will have a difficult time identifying their responsibility toward their community or even their school and peers. Some may not recognize that they have specific, personal responsibilities in these areas, while others may feel personally burdened with responsibilities that are beyond them. As students work through the activities in this program, they will learn how responsibility can be both an individual and a group concern.

To measure students' understanding of responsibility before and after they complete the activities, you might discuss the following situation

with them – determining who is responsible, how they are responsible and why.

*A group of teens is hanging out on a street corner, just talking and clowning around. One teen challenges another to see who can take out the street light. They begin tossing rocks, until the light breaks. Several days later, a young boy runs out into the road and is almost hit by a car because the driver didn't see him due to the darkness. Local residents complain to town officials about the broken light and the dark corner, wanting to know why it wasn't fixed. Whose responsibility was it to keep that corner safe by having a working street light?*

Initially students may think it is the responsibility of the public works or police departments to keep the light working. After completing the activities in this program, students should recognize that the responsibility is actually shared by town officials as well as the kid who broke the light, and the other kids present, who were responsible for not stopping the damage and then for not reporting it.

Building upon the decision-making skills and techniques taught in earlier RIGHT DECISIONS, RIGHT NOW units, students will continue to exercise their skills in a series of activities that reflect real-life situations. As students complete the activities, they will be encouraged to reflect upon the factors that influence their decisions and to apply decision-making skills that they have learned to specific situations. The program will culminate with students using their decision-making skills to create a "teen guide" that will help them make the right

decisions as they travel the road of life. The guide will be general in nature, but will include tips that are applicable to almost any tough decision-making situation in which students find themselves.

### Intended Audience

The RIGHT DECISIONS, RIGHT NOW program has been designed to be used with students in grades 6-9. The materials can be incorporated into social studies, health or life skills classes.

### Objectives

This unit of the RIGHT DECISIONS, RIGHT NOW program is designed to help students:

- recognize their responsibilities to themselves and others – both now and in the future.
- understand the importance of making commitments and being responsible for seeing those commitments through.
- realize that they play an important role in society, and develop in them a feeling of empowerment that they can help guide the success of their school and community.
- use the skills and insights they have learned in previous units pertaining to decision-making, consequences of decisions, refusal skills, values and conflict resolution as they take on responsibility.
- gain confidence and a positive self-image.
- learn to work cooperatively with their classmates to create an atmosphere within their school, and community, in which students take responsibility for their own actions and those of their peers:

## Introduction

Introduce the activity by clarifying with students the meaning of the word responsibility. Write the word on the chalkboard and ask students to give you words, phrases or sentences that come to mind when they hear this word. Then use students' answers to write a class definition for responsibility. Extend the discussion by asking students to share their concepts of what their responsibility might be to the community, to the school and to themselves.

As you distribute the worksheet for Activity One, tell students that they are going to explore these issues, beginning with their responsibility to the community, by looking at specific situations and determining who is responsible and what their roles would be.

## On Your Own

Encourage students to use this part of the activity to examine their own feelings and beliefs as they determine their responsibility to the community, other citizens and to themselves. Conduct a class discussion on this part of the activity before students go on to their group work. Remind students that they do have choices in what they should do, cautioning them not to try to be heroes in situations that involve danger.

## In Your Group

Have group leaders call their groups together to complete this section of the activity. Set a time limit that is appropriate for your class, after which you will ask the recorders to report their group findings to the class. Encourage them to focus on the differences between those group

members who felt responsible and those who did not. Elicit from students how attitudes can affect the actions of community members. You might also ask students to share any difficulties they had in defending a position that was not their own. Discuss the value of "stepping into someone else's shoes" for a discussion like this.

## Extending the Activity

1. Ask students to share some projects that they are involved with that show responsibility toward the community. Some of these might be recycling, actively practicing and encouraging others not to litter, working with voluntary organizations or individually to help others, perhaps with improving reading or other school subjects, helping the elderly with yard work or carrying groceries, etc. Take this opportunity to encourage students to volunteer, perhaps having each student make a commitment to helping someone in need for a week or more.
2. Ask students to scan the newspaper for a week, clipping and compiling articles that deal with community issues. Using those articles, have students identify who is responsible for taking some form of action in each one. Students should be prepared to give reasons for identifying the "responsible" individuals or officials.

## Activity Two Your School ... what is your role?

### Objectives

- To help students evaluate and define their responsibilities to their school community.
- To help students recognize the many decisions they make while at school.
- To allow students to see the importance of those decisions that may impact their goals for the future.

## Introduction

Many of the decisions that students make at school will involve friends or classmates, with peer pressure and peer influence playing an important role in the final decision. You might review the concepts of *peer pressure* – overt pressure such as teasing, challenging or dropping someone from a friendship or group – and *peer influence* – the pressure students put on themselves to be a part of the group. Guide the discussion so that students can see how these powerful factors might conflict with their sense of responsibility when making decisions.

## On Your Own

As students complete this part of the activity, remind them to think about these actions in terms of responsibility to teachers, other students and themselves. Then they should think about how most students would react to each action noted and base their recommendation on those reactions as to whether there should

be rules about these things, or they should be left up to the individual students to decide.

## ***In Your Group***

Have each group leader call the group together to share their thoughts on the On Your Own part of the activity and to debate one of the two propositions. Depending upon your class, you can have students debate either formally or informally. If you choose to have a formal debate, review the debate format: (1) opening statements from both pro and con teams, (2) questions from pro to con, (3) answers from con, (4) questions from con to pro, (5) answers from pro and (6) closing statements from both pro and con. Encourage students to write down the key points they wish to highlight so that they can refer to them during the debate. Remind students that they might anticipate the opposition's statements and questions by "stepping into their shoes" and looking at the issue from another perspective.

Since preparing for a debate may take additional time, you may wish to extend this part of the activity over two or three class periods. Once the groups are ready, have them debate before the entire class. When all groups have had an opportunity to debate, the class can discuss any interesting ideas that evolved from this exercise. Perhaps they might wish to take responsibility for their actions and the actions of those around them by following through and implementing some new rules or guidelines for their school. Caution them, however, to work through the student council or the administration.

## ***Extending the Activity***

1. Invite the principal and student body council members to your debates. Ask your students to share what they have learned about community, responsibility, commitment, issues and values with those guests.
2. Students might take a poll of their classmates' concerns or issues at school. They should graph and discuss the results before presenting them to the administration and/or student body council.

## ***Activity Three I Believe . . .***

### ***Objectives***

- To help students clarify their sense of personal responsibilities.
- To help students determine what they value and what their goals might be.
- To allow students to define themselves as individuals.

### ***Introduction***

As you move from the social responsibilities featured in Activities One and Two to personal responsibilities, invite students to compare the two by creating two lists: one of responsibilities they feel are their own; the other of responsibilities they feel others – especially adults – impose upon them. Some examples:

- Taking care of possessions
- Completing homework assignments
- Being home at a reasonable time
- Taking care of their appearance
- Showing respect for older people
- Performing tasks at home

Some students might list all these as imposed responsibilities, while others will say they feel some measure of personal responsibility for one or more items on the list.

Close your discussion by pointing out that even our personal sense of responsibility can be influenced by commonly held beliefs and attitudes.

## ***In Your Group***

Before students meet in their groups, talk about sayings that represent people's beliefs. Give an exaggerated example such as "only tall people are good at basketball." Discuss the validity of this statement with students (is it true, what is tall, what is good, etc.) If a short person truly believed this, how might it affect his or her attitude and actions in playing basketball or trying out for the basketball team? Explain that they will be doing an exercise to see how specific sayings might affect how they act.

Once the groups have completed the exercise, invite them to share their findings in a class discussion. Help students understand that if they agreed with numbers 2, 3, 5, 7 and 8, they probably believe that things outside their control rule their lives. Encourage and help these students to find ways to develop a more positive outlook and gain control over their own lives. Those who agreed with numbers 1, 4, 6, 9 and 10 probably have a more positive outlook and control over their lives. Encourage these students to continue to take charge of their lives and make decisions that are right for them.

## ***On Your Own***

Explain to students that many organizations have credos to help them remain focused on their beliefs and/or mission. Discuss with students why this might be important to an organization and to an individual. Research has shown that organizations that have a written mission statement succeed in accomplishing that mission more often than those that don't have a written mission.



## Program Components

1. Four activity masters to reproduce as individual and group worksheets.
2. This teacher's guide that contains:
  - suggestions for introducing and presenting each activity.
  - ideas for extending each activity.
  - a list of resources for additional information.
3. A full-color poster that encourages students to remember that making the right decisions is important in achieving positive goals.
4. A teacher response card that allows you to comment on the program. Please return this card to ensure that you remain on our mailing list and receive future free educational programs.

## Implementing the Program

### Introducing the Activities

As you present each activity, plan to give students enough background information to prepare them for completing the On Your Own and In Your Group parts of the worksheet. Through exploring their own beliefs and working within groups, students will examine many aspects of responsibility and how it operates – in their community, in their school and in their own lives. Then you can reconvene the class, sharing students' findings and feelings about responsibility.

## Group Work

The program is designed for students to work collaboratively on one portion of each activity. If your class is already arranged for cooperative learning, use your groups of 4-6 students. Otherwise, group students randomly or by a selection method that works well for your class. You can have students remain in the same group throughout the unit or change groups for each activity.

Each group will need a group leader and a recorder. The group leader is responsible for facilitating the group's discussion and keeping the group focused on the task. The recorder will record the group's comments, discussion and/or answers, and report the group's conclusions to the class. These roles should change with each activity.

The following rules should be introduced to the entire class in the beginning of the unit, then reiterated by the group leader before each group activity:

1. Students may pass if they feel uncomfortable sharing about certain topics.
2. No put-downs.
3. Students must take turns talking and contributing to the discussion.

## Poster

The poster encourages students to take charge of their lives by accepting responsibility for their own futures. It contains some simple tips – tools for making decisions. These tips are comprised of the skills and techniques that students learned in earlier units of the RIGHT DECISIONS, RIGHT NOW program. Display the poster in your classroom so that you and your students may refer to it when neces-

sary. Encourage students to continue using these tips both inside and outside of school for greater success in achieving their personal goals.

## Follow-Up

After you have completed this unit:

- encourage students to continue sharing situations that call for responsibility and commitment.
- offer positive feedback for students who exhibit the qualities discussed here.
- encourage students to share any news articles that feature people who exhibit both positive and negative examples of responsible behavior.
- reward and praise students who are positive role models inspiring others to act responsibly. Also encourage your students to find those role models among their peers.
- invite committed parents or members of the community who exemplify responsibility to your classroom as guests. Your guests might share their experiences with your students, or simply be honored with a reception.

## Activity One Your Community ... who's responsible?

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## Objectives

- To help students gain a better understanding of community and their roles as members of a community.
- To allow students to explore and define their personal values in relation to their roles as members of a community.

## Extending the Activity

1. Have students collect credos (mottos) from organizations, such as Boys' or Girls' Clubs, the United Way and/or individuals in their community. Share these with the class without telling who the credo belongs to. Let the students guess whose credo is being shared and what it signifies.
2. Invite students to turn their credos into raps or songs. Students might even work in groups, performing their "solos" in sequence.

## Activity Four The Road to Success...

### Objectives

- To help students identify tough decision-making situations they are coping with now or think they might encounter.
- To give students some sound ground rules for handling difficult situations.

### Introduction

Most young people approach adolescence with both excitement and trepidation. The aura of independence can be quite exciting, yet brings with it myriad fears about obstacles they may encounter. As students begin to set goals for their future, they will also need to establish ways to overcome any obstacles that might prevent them from fulfilling their goals.

Explain to students that having a plan to deal with any difficult situation or obstacle that they anticipate can relieve feelings of uncertainty or pressure they may be experiencing and give them greater control. This activity will give them

an opportunity to work together to create a guide that helps them deal with obstacles, especially those involving tough decisions.

### On Your Own

Once students have had ample time to complete the section, encourage them to state their goals and concerns. If you find students with similar goals and concerns, you might group them together for the In Your Group portion of this activity.

### In Your Group

Have students gather in their groups to create a guide for themselves. As they create their guides, encourage them to refer to the poster for ideas. For example, they should think about both short- and long-term consequences of any decision, whether it be a simple one such as studying or going to a party, or a tougher one such as smoking or drinking. Knowing when and how to say No can give them an advantage. An important part of decision-making is to know your beliefs (credo from Activity Three) and to live by them. Finally, students should practice their decision-making skills to help them take control of their own destiny.

## Extending the Activity

1. Invite a counselor to review and discuss the guides with your students. Ask the counselor to give resources and support services available for students who might encounter problems that require more detailed attention.
2. Give each student a large piece of paper and direct them to write one important personal goal at the top of the paper. Then ask students to create a "road map" that shows how they will reach this goal in time. Give examples on the board and remind students that goals

are not achieved without a lot of planning and hard work.

## Culminating Activity

Create a class mural that depicts a roadway to the future. Invite students to draw themselves near the end of the road as they see themselves in the future. They should also include themselves on the roadway now – with symbols such as sports equipment or computers – that show what they can do now to help reach that future goal. Display the mural for all to appreciate.

## Resources for Teachers

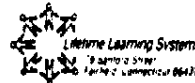
E. L. Feindler & R.B. Ecton, *Adolescent Anger Control*. Pergamon Press, 1986.

Ann Donegan Johnson, *The Value of Responsibility*. Value Communications, 1978.

B. Johnson, ed., *Dealing with Social Problems in the Classroom*. Kendall/Hunt Publishing Company, 1982.

L.D. Johnson, *Monitoring the Future: A Continuing Study of the Lifestyles and Values of Youth*. Institute for Social Research, 1989.

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**RIGHT  
DECISIONS  
RIGHT  
NOW**

# Activity One

## Your Community

### ...who's responsible?

"It's not my responsibility." That's a common response to a task that someone does not want to do, especially when it's a task that takes community action. But who is responsible for keeping our neighborhoods clean and peaceful, our neighbors safe and healthy, our nation prosperous and strong?

#### Part One On Your Own

Below are some situations that you might find in any community across our nation. Pretend that you have observed each one and complete the form to indicate who you think is responsible for taking care of the situation and what *your* responsibility might be – what you should do.

Situation	Who is Responsible?	What Should You Do?
1. An abandoned car has been in your neighborhood for several weeks	_____	_____
2. Some kids are planning to knock over headstones in a cemetery for fun	_____	_____
3. Two kids are fighting. One goes home for a weapon.	_____	_____
4. A homeless person has been hanging around the neighborhood looking for food and money	_____	_____
5. There is a rumor of a drug deal at a certain time and place	_____	_____
6. A new family moves into the neighborhood	_____	_____
7. An older person is being bullied	_____	_____

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#### Part Two In Your Group

**Group Leader:** Call your group together to discuss the situation below, focusing on responsibility. Before your group gets together, make up a slip of paper for each group member. On half of the slips of paper write "not responsible," on the other half write "responsible." Explain to group members that the paper they draw determines the part they play in the discussion. Some of them will pretend to feel responsible for doing something about the situation. Others will pretend to feel no sense of responsibility. Be sure members understand that the part they play does not have to reflect their true feelings.

**Recorder:** Record group members' comments. Be sure to list them under whether the member feels responsible or not responsible.

#### Situation

There's a mini-market not far from your school. Although it is against the law for any store to sell tobacco products to underage persons, you have heard that it's easy to buy cigarettes at this store. Yesterday, you were in the store with some friends from your class, and you watched while Josh and Michael, who sometimes smoke, went up to the counter and bought cigarettes with no trouble at all.

**Group Leader:** Take the discussion a step further and talk about how attitudes toward responsibility can affect a community, either positively or negatively. The recorder can help get this discussion started by reviewing group members' comments.

**RIGHT  
DECISIONS  
RIGHT  
NOW**

# Activity Two Your School ...what is your role?

All students unite behind their sports teams, trying to cheer them on to victory. But are the students in your school united about the day-to-day actions that help make the school run smoothly? And who is responsible for the day-to-day actions of students – the students themselves? the teachers? the administration?

## Part One On Your Own

Several school-related actions are listed here. Decide whether they are actions that need rules or if they are actions that students should take responsibility for personally. You can indicate your decision by writing an R next to the ones that you feel need rules and a P next to the ones for which you should take personal responsibility. If you feel both are appropriate, write R/P.

### School-Related Action

Being late for class  
Doing your homework  
Studying for tests  
Fighting on school grounds  
Treating others in a friendly manner  
Wearing gang-related items  
Smoking on school grounds  
Bringing alcohol to school functions  
Loud and boisterous behavior  
Reporting students who do any vandalism to the school  
Carrying weapons to school

### Rule/Personal Responsibility

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## Part Two In Your Group

**Group Leader:** Get your group members together. Explain that they should think of themselves as members of the student council as they complete this activity. The student council is responsible for proposing, discussing and enacting rules that are to be followed by the entire student body at your school. Read the following propositions. Have your group select one to debate. Divide the group in half. Assign one half of the group to stand in support of the proposition (Pro), and the other half to stand against it (Con). Then give the groups time to plan their arguments for a debate.

**Recorder:** Record the proposition selected by your group. As group members debate the issue, list the points each side – pro and con – bring up. Be ready to review these points with the group, highlighting the ones the group wishes to present to the class.

### Proposition One

It has been proposed that a dress code be adopted at your school. Girls must wear dark-color skirts that are flared and fall below the knee. Boys must wear dark-color pants. Tops will consist of light-color blouses or shirts, such as white or pastels. Flat, dark shoes will be worn – no sneakers. Girls may wear scarves and boys ties. But no excessive jewelry, scent or make-up may be worn.

### Proposition Two

It has been recommended that a zero-tolerance policy concerning violence be instituted for your school. Anyone found having a weapon in school, fighting on school grounds or acting in a threatening or intimidating manner will be expelled for the remainder of the school year. There will be no exceptions.

**RIGHT  
DECISIONS  
RIGHT  
NOW**

## Activity Three I Believe...

"What do you believe and how did you get those beliefs?" Could you answer this question right away if someone asked you? Most people would need to think about it for a while. Our beliefs are really an accumulation of many things – the influence of family, friends and peers; our values; the things we hear. Some of the things we hear over and over can guide our beliefs, and, consequently, the way we live. As you work with your group, you'll get a chance to examine some of those "life sayings" that you hear again and again.

### Part One In Your Group

**Group Leader:** Ask each member of your group to check agree or disagree for each statement. When everyone is finished, read the first statement aloud. Then ask for a volunteer to explain the meaning of the statement. When your group agrees on the general meaning, ask who agrees and disagrees with the statement. Discuss the reasons for each opinion, then move on to the next one.

- |   |                                |                                   |
|---|--------------------------------|-----------------------------------|
| 1. Skills make the person.                                | <input type="checkbox"/> Agree | <input type="checkbox"/> Disagree |
| 2. It's who you know that counts.                         | <input type="checkbox"/> Agree | <input type="checkbox"/> Disagree |
| 3. Street smarts are better than book smarts.             | <input type="checkbox"/> Agree | <input type="checkbox"/> Disagree |
| 4. Having people respect and look up to you is important. | <input type="checkbox"/> Agree | <input type="checkbox"/> Disagree |
| 5. Might is right.  | <input type="checkbox"/> Agree | <input type="checkbox"/> Disagree |
| 6. Treat others the way you wish to be treated.           | <input type="checkbox"/> Agree | <input type="checkbox"/> Disagree |
| 7. It's not who you are, but how you look that matters.   | <input type="checkbox"/> Agree | <input type="checkbox"/> Disagree |
| 8. Money talks.   | <input type="checkbox"/> Agree | <input type="checkbox"/> Disagree |
| 9. It's not what you say, but what you do that matters.   | <input type="checkbox"/> Agree | <input type="checkbox"/> Disagree |
| 10. Hard work pays off.                                   | <input type="checkbox"/> Agree | <input type="checkbox"/> Disagree |

### Part Two On Your Own

#### My Credo

A credo is a statement of beliefs, principles or opinions that a person or group of people hold and live by. Think of the ideas, the beliefs, that help guide your life. Use these ideas to help create a credo for yourself – a guide that helps you know who you are and what you believe.

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On the back of this sheet, create a crest to accompany your credo. Draw symbols and designs on your crest to illustrate what you stand for in life.

**RIGHT  
DECISIONS  
RIGHT  
NOW**

# Activity Four The Road to Success...

You're in the driver's seat when it comes to the road you want to travel in life. What do you see for yourself down that road? As you know, life is not always smooth. Sometimes you hit obstacles or rough spots along the way. These times can be easier, however, if you have a guide or plan to help you over them.

## Part One \_\_\_\_\_ On Your Own

Name a goal you've set for yourself – either a short-term or a long-term goal. Then list some obstacles you might encounter that would hinder you from achieving that goal. Some examples might be: whether or not you hang out a lot, join a gang, smoke or drink; who or how often you date; the friends you choose.

Goal:

\_\_\_\_\_

Possible Obstacles to Achieving Your Goal:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Part Two \_\_\_\_\_ In Your Group

**Group Leader:** Bring your group together to create a "teen guide" for getting through the rough spots in life. Ask members to share their goals and any obstacles they've identified. They should mention specific situations they feel they might find themselves in, and how their choices could affect their achieving their goals. Then brainstorm ways they can prepare for those obstacles and tough decisions.

**Recorder:** List all the ideas that members give for each section of the guide. Then go back and star the ideas the group thinks will work best. Use these ideas to formalize your guide.

**Group Leader:** Be sure each group member makes a copy of the guide for reference.

## A TEEN GUIDE

### Tips for Making The Right Decisions

**Routine Maintenance:** What should you do regularly to keep yourself in top shape for making the right decisions? List here five specific things every teen should do. Some tips might focus on things such as a positive attitude, being goal-oriented or keeping self-control.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**Rules of the Road:** There are millions of other teens cruising the highway of life. List five rules for keeping things running smoothly. Some rules might deal with such topics as avoiding conflict, negative peer pressure, prejudice or showing respect for others.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**Troubleshooting:** What are some of the signs that a tough decision might be coming? How can you fix the problem before you need a major overhaul? Some examples are given. You add to the list.

#### Signs of Trouble

#### How to Handle It

Poor grades

Withdrawn or depressed

Arguments at home

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**In an Emergency:** How can you handle a tough decision on the spot? Some examples are given. You add others.

#### Emergency Situations

#### What To Do/Who To Call

Offered a cigarette

Dared to steal

Pressured to drink

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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# YOUR FUTURE IS IN YOUR HANDS!

**RIGHT  
DECISIONS  
RIGHT**

**Take**

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# Responsibility for It



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responsibility





Success



Ability

51604 6108



Leadership



Peer



**THINK** *about the **consequences** of your decisions – both short- and long-term, for yourself and for others.*

*when and how to  
– and do it.*

**FOLLOW** *positive beliefs and **values** – ones that are important to you.*

**PRACTICE** *making well thought-out decisions to help you along the road to success.*

DO  
IT  
?  
THEN  
WHAT  
?

## Dear Educator:

The news is full of stories about young people carrying guns to school, joining gangs, using drugs and pursuing many other risk behaviors. One reason that so many young people engage in these behaviors is that they feel powerless. Teens who suffer from low self-esteem tend to think that they are being moved by forces beyond their control, such as having to do whatever their friends want (or what they think their friends want). Helping your students develop their skills as decision makers is one of the best ways to prepare them to reject risk behaviors.

With experience and guidance in making decisions, your students can gain a new sense of confidence and self-direction. By learning to look at the consequences of their actions — particularly long-term consequences — they can begin to recognize that they have a strong measure of control over shaping the events in their lives.

This study guide is a part of the RIGHT DECISIONS, RIGHT NOW program which is designed to help students develop the capacity to make the decisions that are right for them. The program is funded by the R.J. Reynolds Tobacco Company, which firmly believes that children should not smoke. Developed for use with students in grades 6-9, the activities help students examine the consequences, both immediate and future, that could result from the decisions they make.

We encourage you to share this exciting program with your colleagues. Although the materials are copyrighted, you have permission to make as many copies as you need for educational purposes.

Once you have had an opportunity to review the program, **please take a moment to complete and return the enclosed response card.** Your comments help us to create programs that continue to meet your needs. Returning this card also ensures your continued receipt of free educational programs.

Enjoy watching your students gain a sense of confidence and self-direction as they complete the activities in this program, learning to make the right decisions for themselves, right now!

Sincerely,



Dr. Dominic Kinsley  
Editor in Chief

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**RIGHT  
DECISIONS  
RIGHT  
NOW**

**LIFETIME LEARNING SYSTEMS, INC.**  
... an Experience in Dynamic Education

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## INTRODUCTION

According to a 1990 study by the National Institute on Drug Abuse, *Adolescent Peer Pressure: Theory, Correlates and Program Implications for Drug Abuse Prevention*, and other research, grades 6 and 7, in particular, are the most important grades for reaching students and preventing risk behaviors. By the time students reach grades 8 and 9, their doubts about their own identities and values makes the task more challenging.

This study guide is a continuation of the RIGHT DECISIONS, RIGHT NOW program. The materials and teaching suggestions are designed to improve students' decision-making skills by helping them focus on the immediate and future consequences of their decisions and the effect their decisions might have on other people.

The previous RIGHT DECISIONS, RIGHT NOW study guide, which you received at the beginning of the school year, emphasized the role of peer pressure and peer influence on the decisions young people make. You may wish to review these two forms of pressure before you begin this phase of the program.

- **Peer Pressure** — Adolescents may be taunted or teased into doing something they don't want to do or that they know is wrong. (E.g., "My friends smoke. They are pushing me to start. I don't want to be different, so I'll do it.")
- **Peer Influence** — Young people who engage in risk behaviors often do so because they assume they have to in order to be accepted, to be liked or to have and maintain friendships. No outside pressure is applied; instead, the individual creates an internal pressure out of the desire to fit in. (E.g., "The cool kids in school smoke. I want to be cool, too. I'll start smoking, so I can be like them.")

The previous materials also developed

six mental steps involved in the decision-making process:

1. Identifying the conflict that makes a decision necessary.
2. Setting a goal.
3. Weighing the alternatives.
4. Considering the consequences of each alternative.
5. Arriving at a decision.
6. Reflecting on that decision.

In this phase of the RIGHT DECISIONS, RIGHT NOW program, students will review those steps and then concentrate on analyzing the short-term results and possible future consequences of the kinds of decisions they may face in the near future and beyond. The role of peer pressure and peer influence on those decisions will be analyzed as well.

## INTENDED AUDIENCE

This program is designed to be used with students in grades 6-9 in social studies or health classes. The activities are developed to help students look beyond the immediate, and focus on the future consequences of their actions.

## OBJECTIVES

This phase of the RIGHT DECISIONS, RIGHT NOW program is designed to help students:

- review the difference between peer pressure and peer influence.
- review and apply the mental steps involved in making a decision.
- recognize that most decisions have both short- and long-term consequences.
- identify ways in which their decisions can affect other people.
- analyze warning labels as sources of information about short- and long-term consequences of using specific products.
- examine a variety of risk behaviors in terms of immediate results and future consequences.
- identify sources of helpful information about the possible risks and consequences of important decisions.

- gain experience and confidence in making personal decisions.

## PROGRAM COMPONENTS

This program contains the following components:

1. This Teacher's Guide which includes:
  - A statement of program objectives.
  - Background information.
  - Suggestions for presenting each activity.
  - Ideas for extending each activity.
  - A list of resources.
2. Four Activity Masters to reproduce as individual worksheets for students.
3. A full-color poster that encourages students to think about the consequences of decisions they may make now.
4. A teacher response card which allows you to comment on the program. Return this card to ensure that you remain on our mailing list and receive future free educational programs.

## USING THE PROGRAM COMPONENTS

### Activity Masters

Use a photocopier or other school equipment to make copies of each Activity Master to serve as individual worksheets for students. The activities are presented in an effective learning sequence, but you may wish to change the sequence to meet the needs of your students.

### Poster

Display the poster in a prominent place in the classroom and use it to introduce the program. Remind students that making a decision involves a lot of thought processes. Using the poster's example of deciding whether or not to drink, discuss some of those processes.

Ask students to identify some of the thoughts that probably go through the girl's head as she makes the decision. Elicit from students that some consequences, such as fitting in with the group or forgetting problems, may seem good at the time but, when looked at over the long range, are not so good.

After going through the decision-making process, ask students to identify the decision the girl made (not to drink) and why they came to that conclusion. Talk about what might have happened if she had made the decision to drink.

## Activity

### THE DECISION TRACK



Introduce this activity by reviewing the six mental steps involved in making a decision and list them on the chalkboard: 1. identifying the *conflict* (often referred to as "the occasion for making a decision"); 2. setting a *goal*; 3. weighing the *alternatives*; 4. considering *consequences*; 5. arriving at a *decision*; 6. *reflecting* on the decision. Remind students that our minds do not go through this process in a neat and orderly way. Instead, one step flows into another and sometimes we jump around from one to another and back again. In addition, we sometimes short-circuit the process and act on impulse or give in to outside pressure from friends. But, when we take the time to think about an important decision, knowing about the steps can make a big difference. In fact, some very successful people actually write out every step in the process when they are faced with a tough decision. (This practice may have originated with Benjamin Franklin.)

### Part I

Distribute the activity sheets and have students define each of the steps in their own words. **Caution students**

not to write examples at this time. Take time for students who may have questions or may want to talk about the process. As you finish the discussion about the steps involved in making a decision, point out the importance of going through the steps, especially reflecting on one's decisions.

Explain that most of the life-shaping decisions we make can be reversed; if, upon reflection, a person does not feel right about a decision such as dropping out of school or experimenting with drugs, it is often possible to go back through the steps, rethinking the alternatives and the consequences. Even when a decision is made that results in negative consequences, young people can help stop them by going back through the process, making new decisions.

### Part II

Take students through the process step by step, using the example of a student making the decision whether or not to begin smoking. Some of your students may have already made the decision to smoke. Without pointing fingers, you can use the Decision Path to talk about how students their age might come to this decision. Use the following questions and suggestions to initiate a discussion.

- What steps did they go through?
- How was peer pressure or peer influence likely to be involved?
- Then remind students that most decisions can be reversed. Suppose, for example, on reflection, a student is not happy with this decision. Elicit from students that by going through the steps in a reasonable manner, the person may come up with a different decision.

### Extending the Activity

1. Use biographies or novels the students are reading to find examples of the decision-making process at work. Encourage students to identify the decision

and the factors that led a person to make an important, life-shaping decision. Working in pairs or small groups, students can even chart the steps involved in the individual's decision path.

2. Invite an adult who would be a role model for your students to talk with the class about an experience in making a difficult decision. Ask the visitor to talk about what was involved in making a decision that might have been unpopular (not going along with the crowd) or that involved overcoming temptation (turning away from smoking or using alcohol or other drugs).
3. Encourage students to scan newspapers, looking for stories about young people who have achieved a goal. Then have students speculate about decisions these young people might have faced, what forces may have influenced them, etc.

## Activity

### THINK ABOUT TOMORROW



Most adolescents tend to think only about the immediate results of their decisions. If they do think about future consequences, their attitude is usually reflected in statements such as "It won't happen to me" or "That's a long time away."

To get students thinking about future consequences, ask them what a parent or other adult means when giving a warning such as, "Think about the consequences." Encourage students to give their own interpretations of the phrase and invite them to share examples of when they, or someone they know, heeded the warning or failed to heed it. You might give them a couple of examples to get them started. One example can be as simple as: "The weather forecast was for a cold front arriving later in the day. Jack heeded the warning and wore a

warm jacket. Later in the day, when the cold front arrived, Jack was glad he had heeded the warning." A more critical example might be: "Sara went into the video store with some friends. She saw the cameras set up and read the sign that said 'Shoplifters will be prosecuted.' Sara ignored the warnings and stole a video. As she left the store, Sara was stopped by security. She was taken to the police station where she was arrested and her parents called. Sara was banned from the video store, grounded by her parents and ordered by the court to complete one hundred hours of community service." Use the discussion to develop the idea that consequences can be immediate (you steal something and are caught), and they can also involve the future (having a police record or a reputation for dishonesty, which also have future consequences such as difficulty in obtaining jobs).

## Part I

Divide the class into groups of three or four to complete the chart on the activity sheet. Before students begin, remind them that both immediate results and future consequences can be positive, negative or both.

When all groups have finished Part I, discuss the results. You can use the following questions as discussion starters:

- In what ways were the students' responses similar?
- What differences emerged?
- In what ways did peer pressure or peer influence affect results?

In situations 1, 2, 4 and 6, students may feel that one immediate result was maintaining friends or a sense of belonging to the group. In situations 3 and 5, they are likely to say that the decision will be unpopular with friends. You might want to talk about the students' responses to those two situations. Ask:

- Do you think the decision made was realistic?

- How difficult would it be in either situation to resist the pressure of friends?

Discuss the kinds of long-term consequences the groups came up with and how far into the future they carried their analysis. For example:

- Did any of the groups feel that a long-term risk of starting to smoke might be lung cancer, emphysema or heart disease?

Use the smoking example to introduce this important question:

- Why do young people who know what the future consequences might be still engage in risk behaviors like smoking?

Your students are likely to express a number of opinions, such as:

- giving in to the pressure of friends.
- kids don't think about the future.
- they don't think the consequences will affect them.
- they don't care about the future.
- adults do it, so why can't they?

Encourage discussion of the question as long as it seems profitable. The discussion itself will help some students realize that the decisions they make now can affect them far into the future.

## Part II

Keep the class in the small groups to work on Part II, choosing two of the situations for each group to discuss. Students should use their imaginations in considering how others might be affected by their decisions. It is easy enough to think of how a parent or friend might be affected; encourage them to imagine beyond that. For example:

- Who would be hurt by the trashing of the buses?
- How might the joy ride lead to harm to others?

Groups can then take turns drawing webs on the chalkboard to show the other people who were affected by the decisions.

## Extending the Activity

1. Allow students to choose any of the situations from Part I to write about. Encourage them to change negative decisions to positive decisions before writing. The writing might be a personal narrative, a short story or play with invented characters, a journal entry, or a letter.
2. Challenge the groups that worked together on this activity to design a television commercial that encourages young people to think about the future consequences of their decisions. Plans should include ideas for visual images, music or sound effects and narration. The class can vote on which commercial it thinks would be most effective.
3. Assign each group one of the situations from the activity sheet to role play for the class. Stress the importance of including reasons for their arguments. Encourage the groups to depict the situations realistically, with friends pointing out the immediate and long-term consequences to the main character.

## Activity

### CHECK THOSE WARNING LABELS

Certain products have potential risks associated with their use. Many companies that produce these products must, by law, warn the

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RIGHT  
DECISIONS  
RIGHT  
NOW

consumer about these risks. They do so by placing warning labels on these products. A sampling of these labels is included on the activity sheet.

Introduce the activity by asking students what kinds of warnings they commonly hear from parents or other adults. Have them distinguish between warnings about immediate consequences (E.g., "Put on sunscreen so you don't get burned.") and those involving the future ("You need good grades now if you want to go to college."). Briefly discuss other warnings they see in the community, such as warnings about skate boarding, using a seatbelt and street traffic signs. Point out that, in many cases, the warning provides information about a potential risk, such as approaching a pedestrian crossing when you're driving or that a store uses video cameras to prevent shoplifting.

### Part I

As you distribute the activity sheets, tell students that other kinds of warnings can be found right in their own homes — in the form of warning labels on products that have potential risks to the consumer. As students begin Part I of the activity, tell them that they should answer for every product: if they are unsure of the type of product the warning label might be on, they should make their best guess. Also, in analyzing the labels, they should think in terms of both the immediate and long-range consequences. If students do have problems identifying the type of product, you might allow them to work in pairs or small groups.

**Answers:** After students have completed Part I of the activity, use their responses and the following ideas as the basis for discussion:

1. Product: alcoholic beverages. Note that both short-term and future consequences are given.
2. Product: cigarettes. While the warnings involve long-range consequences, you might ask the class what the short-term results of smoking are. Some of the smokers in the class may be surprised by the responses of the nonsmokers.
3. Product: cough medicine. Many over-the-counter medicines carry a similar warning.
4. Product: instant glue. Sniffing the fumes from glue or from various aerosol products has become a disturbingly common form of substance abuse among children. Misuse of these substances can have both immediate and lasting consequences.
5. Product: prescribed pain killers such as percodan or codeine. According to *Growing Up Drug Free: A Parent's Guide to Prevention*, published in 1991 by the U.S. Department of Education, the abuse of prescription medicines is a major problem area for drug addiction. Using these drugs illegally and getting caught is an immediate consequence; addiction is likely to be long-range.
6. Product: electrical appliance. All electric tools and appliances like hair dryers carry warnings about the dangers of use near water.

### Part II

Divide the class into groups to determine other products they feel should have warning labels. Encourage them to devise their own warning labels for those products.

Depending on the age and life experiences of your students, you might use the discussion to raise the question of why people their age would ignore such warning labels. As in the discussion of Activity 2, the question will elicit a variety of responses. Talking about this can

increase students' awareness of the need to think through a decision before they act — to weigh any possible benefits against the short- and long-term consequences.

### Extending the Activity

1. As a homework assignment, have students look for warning labels on products at home. They should copy the labels rather than bring any product to school. Encourage them to find warnings on products that have not been discussed — other kinds of medicines, plastic bags, microwave ovens and television sets or computers. Collect all warning label facsimiles and redistribute, challenging students to identify the products.
2. Divide the class into groups to brainstorm why it would be beneficial for them to make a habit of reading and heeding warning labels. Groups can then share their ideas with the rest of the class.
3. Have students prepare a debate on the topic of banning advertising on or for potentially risky products. Assign two groups to prepare arguments on opposite sides of the issue. Encourage students to cite references from magazine or newspaper articles when debating. Conduct the debate for the full class, with all students voting for or against the ban.

## Activity

### WEIGH THE CONSEQUENCES

Introduce the activity by explaining that students will now have the opportunity to examine the possible consequences of decisions they might face. Each student should choose one of the listed topics to work with, but make sure that all on the list are



dealt with, even if it means assigning topics. Point out that they will be completing the chart for a decision already made.

## Part I

The discussion of Part I will help students recognize the value of thinking in terms of future consequences when they face a life-shaping decision, including the potential impact of the decision on others. Once students have completed their flow charts, use the following questions and ideas to guide discussion:

- What were the reasons for engaging in any of these actions? This is a good opportunity to reinforce the messages that have emerged about peer pressure and peer influence.
- What were some of the immediate results and long-term consequences of each decision? In terms of immediate results, did the person gain what he or she hoped by the action — the approval of peers, feeling good (or high), feeling protected (by carrying a gun or joining a gang)? If so, how were these benefits offset by the long-term consequences?
- Suppose the person you wrote about had thought through the future consequences of the action. Do you think that person might have made a different decision? Why or why not? You can discuss this question in terms of the values the students hold. What value was the person guided by in making the decision? And what values are involved in considering future consequences? Try to draw out the idea that placing a high value on being accepted by peers can blind people to far more important values such as the kind of person they want to be, or what they want to do with their lives.
- Who else do you think would be affected by the decision and how might they be affected? Encourage the students to think

beyond those in the person's immediate circle. Consider, for example, the accidental shootings that result from kids carrying guns or the victims of automobile accidents involving cars driven by youth without licences or those driving after drinking.

## Part II

Have students complete Part II of the activity for the decision they worked on in Part I. You may want to have them research sources of information — using library resources or discussing possibilities with parents, a guidance counselor or a school psychologist.

Discuss the lists in class. Note the extent to which the students rely on friends — or don't rely on them. Students are not likely to include their peer group as a source of information about risks or consequences. Talk about the irony of allowing this group to have a powerful influence on their decisions.

## Extending the Activity

1. Show the class a video dealing with future consequences. There are a number of good ones focusing on substance abuse. *Fast Forward Future* is most suitable for grades 6-7, while *Straight at Ya* is useful with grades 8-9. Both are among a series of programs developed by the U.S. Department of Education and can be borrowed from the Department's Regional Centers. For the address of your Regional Center, write to the U.S. Department of Education, Washington, D.C. 20202 or contact your state education department.
2. Have students develop their own play on the topic of "Weigh the Consequences." Encourage them to think in terms of creating a drama for students two

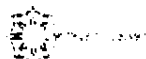
or three years younger than themselves. The process itself will reinforce the learning that has taken place by challenging students to put the ideas in their own words. Polished plays can be video-taped or presented in live performances for lower grades.

3. Invite a speaker such as a social worker, principal, guidance counselor, psychologist or police official to speak to the class about local places they can contact for information to help make them better prepared for making important decisions.

## Resources

- D.S. Elliott, D. Huizinga, & S.S. Ageton. *Explaining Delinquency and Drug Use*. Beverly Hills, CA: Sage Publications. 1985.
- L.D. Johnson. *Monitoring the Future: A Continuing Study of the Lifestyles and Values of Youth*. Ann Arbor, MI, Institute for Social Research. 1989.
- Joyce Tobias. *Kids and Drugs*. Annandale, VA. PANDAA Press, 1987.
- The Rand Corporation. *Teens in Action: Creating a Drug-Free Future for America's Youth*. Rockville, MD, National Institute on Drug Abuse. 1985.
- U.S. Department of Education. *What Works: Schools Without Drugs*. Rockville, MD, National Clearinghouse for Alcohol and Drug Information.

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DECISIONS  
RIGHT  
NOW**



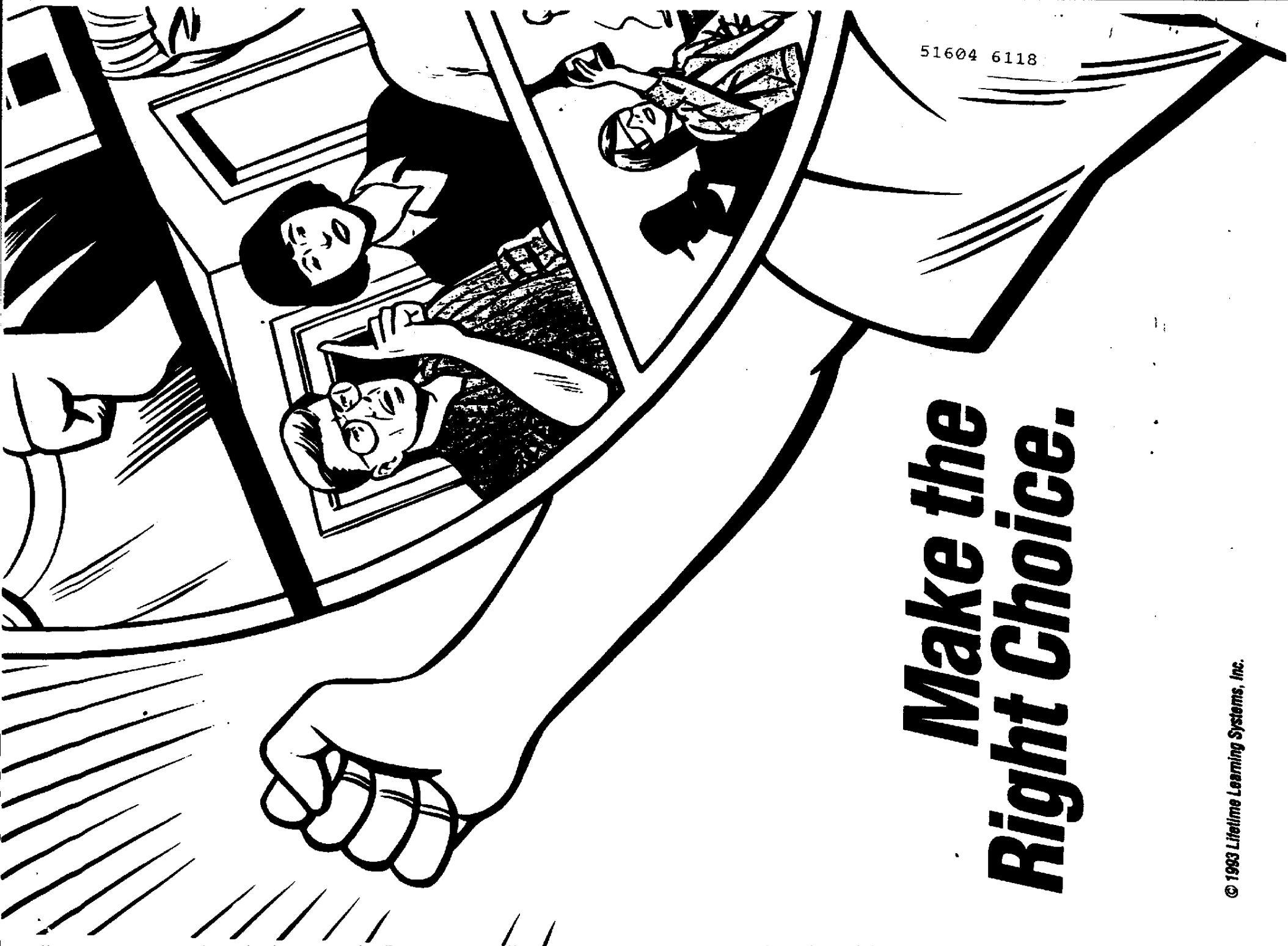
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DECISIONS**  
**RIGHT  
NOW**



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***Make the  
Right Choice.***

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# ACTIVITY

# 1

## THE DECISION TRACK

RIGHT  
DECISIONS  
RIGHT  
NOW

*Making decisions is like breathing. You do it all the time. Some decisions are easy to make. Others require a lot of thought. Remember, whether easy or tough, making a decision involves a process of complex mental steps.*

### Part I

*You've probably been told many times to think before you act. What you're really being told is to take the time to think about the consequences of your decision before you do something. This takes practice. You can start with a workout on the decision track. Beginning with Step 1, explain in your own words what each step means. (Do only this part for each step now.)*

#### Step 1: Conflict What it means:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
**Example:** \_\_\_\_\_  
\_\_\_\_\_

#### Step 2: Goal What it means:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
**Example:** \_\_\_\_\_  
\_\_\_\_\_

#### Step 3: Alternatives What it means:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
**Example:** \_\_\_\_\_  
\_\_\_\_\_

#### Step 4: Consequences What it means:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
**Example:** \_\_\_\_\_  
\_\_\_\_\_

#### Step 5: The Decision What it means:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
**Example:** \_\_\_\_\_  
\_\_\_\_\_

#### Step 6: Reflection What it means:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
**Example:** \_\_\_\_\_  
\_\_\_\_\_

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### Part II

*Now apply your "think before you act" skills to this situation — one that you or a friend might face: Some friends have started smoking and they're putting pressure on you to start. You want them to like you, but . . . Fill in the blanks on the decision track with examples of the steps you would go through in making your decision.*

# ACTIVITY 2

## THINK ABOUT TOMORROW

RIGHT  
DECISIONS  
RIGHT  
NOW

*When you face a decision, you automatically think about the immediate result — what will happen right now. For example, skipping class to go out on a nice spring day is fun. But it can be a lot tougher to think about the long-term consequences — what the future consequences of your decision might be. For example, you get caught. On top of that, you miss an important surprise quiz that you aren't allowed to make up. Think about the repercussions.*

### Part I

*During the next few weeks and months, you will find yourself in situations that require important decisions. Described here are some situations you or your friends might face, along with decisions you might make. Under the heading **Immediate Results**, write what you think might happen right now — good and bad. Under the heading **Long-Term Consequences**, write what you think future consequences might be. Then meet with the group to which your teacher assigns you, and talk about your answers.*

Situations/Decisions

Immediate Results

Long-Term Consequences

**1.** At a party, your friends are all trying pot. You want to be like them, so you try it too.

**2.** At a convenience store, your friend wants to steal a pack of cigarettes. You agree to distract the clerk so your friend won't think you're chicken.

**3.** Your parents are away. Some of your friends show up with beer. Everyone starts to drink. You know it isn't right, so you tell them to stop or leave.

**4.** All of your friends now smoke. You feel like an outsider, so you decide to start.

**5.** One night, things get wild and the group you're with decides to trash some school buses. You know it will mean trouble, so you go home.

**6.** A friend has the keys to his parents' car. He's taking some kids for a ride. You know he doesn't have a license, but you don't want to miss the fun, so you go.

### Part II

*All the decisions you make affect you in some way — good or bad, little or big. Like most people, you probably think mostly about how your decisions will affect only you. But the decisions you make can affect other people, too. Choose two situations from Part I, and on the back of this sheet list who, other than you, could be affected and how they might be affected.*

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# ACTIVITY 3

## CHECK THOSE WARNING LABELS

RIGHT  
DECISIONS  
RIGHT  
NOW

Warnings are nothing new to you. Your parents and teachers have warned you about the consequences of many kinds of actions. Most likely, you've heard warnings on TV about the consequences of using drugs or dropping out of school. But did you know that companies warn you about possible consequences that could result from using some of their products? They do — by placing warning labels on these products.

### Part I

How much do you know about warning labels on products? Check those described below. Complete the chart for each warning label, indicating the kind of product you think would carry the warning, and whether it is about immediate results, long-term consequences or both.

WARNING LABEL	TYPE OF PRODUCT	CONSEQUENCES		
		IMMEDIATE	LONG-TERM	BOTH
1. Consumption of alcoholic beverages impairs your ability to drive a car or operate machinery and may cause health problems.				
2. Surgeon General's Warning: Smoking causes lung cancer, heart disease, emphysema and may complicate pregnancy.				
3. Warning: May be habit forming. Do not take this product for more than seven days. If coughing persists, see a doctor.				
4. Danger: Use only as directed. Inhaling of, or prolonged exposure to the fumes of this product can cause permanent damage to the central nervous system and may be fatal.				
5. This product is a controlled substance, to be used only under a doctor's supervision for the treatment of severe pain. Resale of this product is a federal offense.				51604 6122
6. Warning: Electric shock could occur if used outdoors or on wet surfaces.				

### Part II

Use the back of this sheet to make a list of other products that you think should have warning labels. Then meet with your group to discuss your lists — focus on what is dangerous about the products. Select a product and write a warning label for it. Present the label to the class, asking your classmates to name the type of product for which you wrote the warning.

# ACTIVITY 4

## WEIGH THE CONSEQUENCES

RIGHT  
DECISIONS  
RIGHT  
NOW

*It's easy to get caught up in today and think only about the immediate results of your decisions. It's not as easy to take the time to think about future consequences. But taking the time to weigh the consequences can make life easier later on.*

### Part I

*Some of the important decisions people your age face are listed here. Select one of the decisions and complete the flow chart to show who made the decision, and why you think he or she made it. Then describe what you think could happen as a result of that decision — immediate results, future consequences and others who might be affected.*

using alcohol  
carrying a gun  
running away

shoplifting  
smoking

using drugs  
driving without a license

joining a gang  
dropping out of school

**The Decision Maker**

**The Decision:** \_\_\_\_\_

**Reasons:** \_\_\_\_\_

**Immediate Results:**

**Future Consequences:**

**Others Affected:**

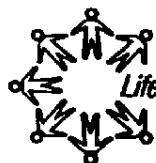
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### Part II

*Even when you want to think beyond the immediate results of your actions, it can be difficult to know what to do. You may need more information to make those important decisions in your life. On the back of this sheet, make a list of sources where you can obtain information, such as people, books, magazines, organizations, etc. Then circle the sources you think would be most helpful to you.*





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Fairfield, Connecticut 06430



# FREE INSIDE!

**Educational program to help students:**

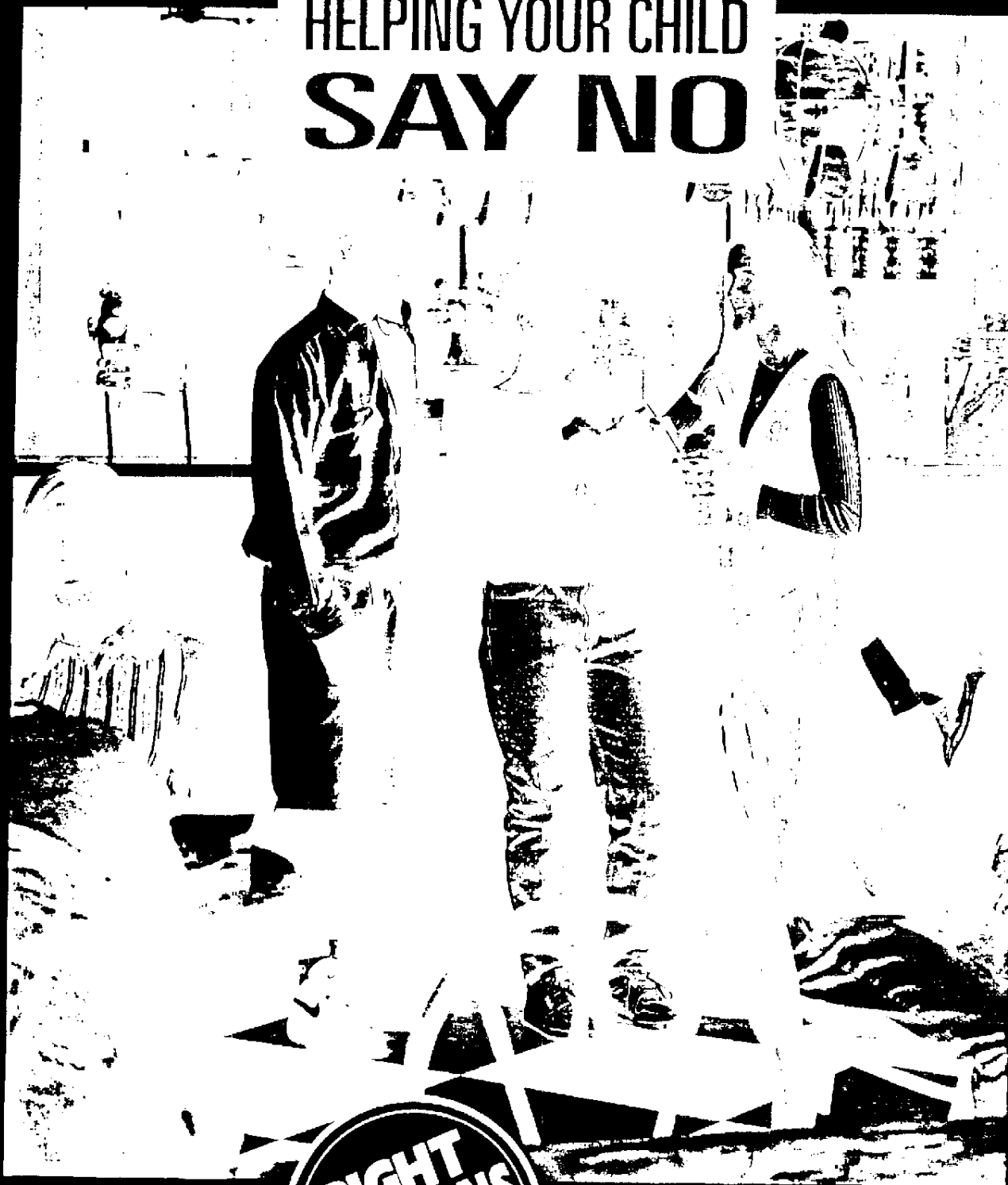
- think about the consequences of their decisions—both now and in the future.
- gain confidence in making decisions—the right decisions for themselves.

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# *Tobacco*

HELPING YOUR CHILD  
**SAY NO**



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**RIGHT  
DECISIONS  
RIGHT  
NOW**

A PARENT'S GUIDE TO HELPING YOUNG  
PEOPLE MAKE THE RIGHT DECISIONS

# GROWING UP IS HARD TO DO

**B**efore we turn to specific advice on how to talk to your kids about not smoking, it's important to briefly discuss the pressures faced by your child as he or she enters adolescence, and your importance to the growth process.

From a parent's point of view, adolescence can look easy--friends, sports, school, video games, TV, parties. What's so hard about that? But think back to your own adolescence. You probably remember plenty of good times. And plenty of not-so-good times. The fact is, growing up is hard to do.

Every adolescent is in the midst of an enormous struggle--to make the transition from childhood to adulthood, and, in the process, to carve out a distinct identity for his or her self. Enormous pressures are placed on them

to excel in sports, academics and other areas such as playing a musical instrument. But the greatest pressure they face comes from within: the pressure to fit in with their peers and develop a comfortable social identity.

## WHAT EXACTLY IS PEER PRESSURE?

Peer pressure is a term often used to describe a direct challenge to a child from one or more peers to engage in some form of inappropriate behavior, such as trying a cigarette. A refusal carries the risk of being teased or taunted, and, depending on the young person's level of self-confidence, this type of pressure can be very hard to resist.

But there's another kind of peer pressure that, although it's less obvious, has a much more powerful effect on the decisions your child will make. It might more accurately be called peer influence. Peer influence is the internal pressure young people impose upon themselves as they try to gain acceptance among friends and classmates. The desire to belong or to fit in socially is very strong in an adolescent. Young people closely observe the appearance and behavior of friends and peers, then borrow those traits they think will help them fit in--things like long hair, provocative clothes, loud music, as well as drinking or smoking.

Peer influence is probably the single greatest motivator in shaping the way your children look and behave. Some peer influences are positive--like the pressure to achieve good grades, excel in sports, be considerate of friends, and act responsibly and grow as a person. But negative influences also abound, and to an adolescent, the temptation to experiment in order to be one of the group is very difficult to resist. This is where you as a parent can make your influence felt.

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**T**his booklet is about helping your children make tough decisions. More important, it's about helping them make the right decisions. As a parent, you know this isn't as simple as it sounds. Children are exposed to thousands of powerful and often competing influences--from teachers and classmates to sports heroes and rock stars to movies and TV. Sometimes, the most important voice of all--yours--can get lost in the din.

One of the decisions children must make--and you must help them make--is not to experiment with smoking. In a perfect world, they'd face this decision only as mature adults. But the fact is, every adolescent will have ample opportunity to experiment with smoking. Deciding not to smoke is a decision they'll have to make consciously and repeatedly--in the face of powerful pressures from friends and acquaintances to try it. As the person they depend on most, you need to help counteract these pressures by adding your voice to the many others--teachers, coaches, guidance counselors, clergy, community organizations and television--that are trying to discourage kids from smoking.

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# THE INVOLVED PARENT

**W**hen children are very young they accept their parents' beliefs unquestioningly and are eager to follow their direction. But as soon as they enter adolescence, things change. They suddenly develop a need to assert their independence and start to resist admonitions to "do this" or "don't do that." This is a normal--even inevitable--part of growing up. They're searching for an identity and practicing for life as independent-minded, self-reliant adults.

As a parent, adolescent behavior can be frustrating, sometimes painful. But you have to resist the temptation to throw up your hands. Now, more than ever, they need your patience, guidance, and understanding.

You need to listen, empathize and be involved. Show an interest in your child's activities. Help him or her set realistic goals. If your son decides to try out for the track team, sit down with him and discuss the commitment that's involved and the rewards of competing. Show your support by attending the events. Regardless of how well he performs, your love and encouragement will help him stick with the decision and give his self-confidence an important boost.

You should resist the temptation to be too critical. This is one of the greatest threats to a loving relationship. If your child isn't performing well, then becoming emotional, criticizing his effort or challenging his commitment isn't going to help. Don't attack your child; attack

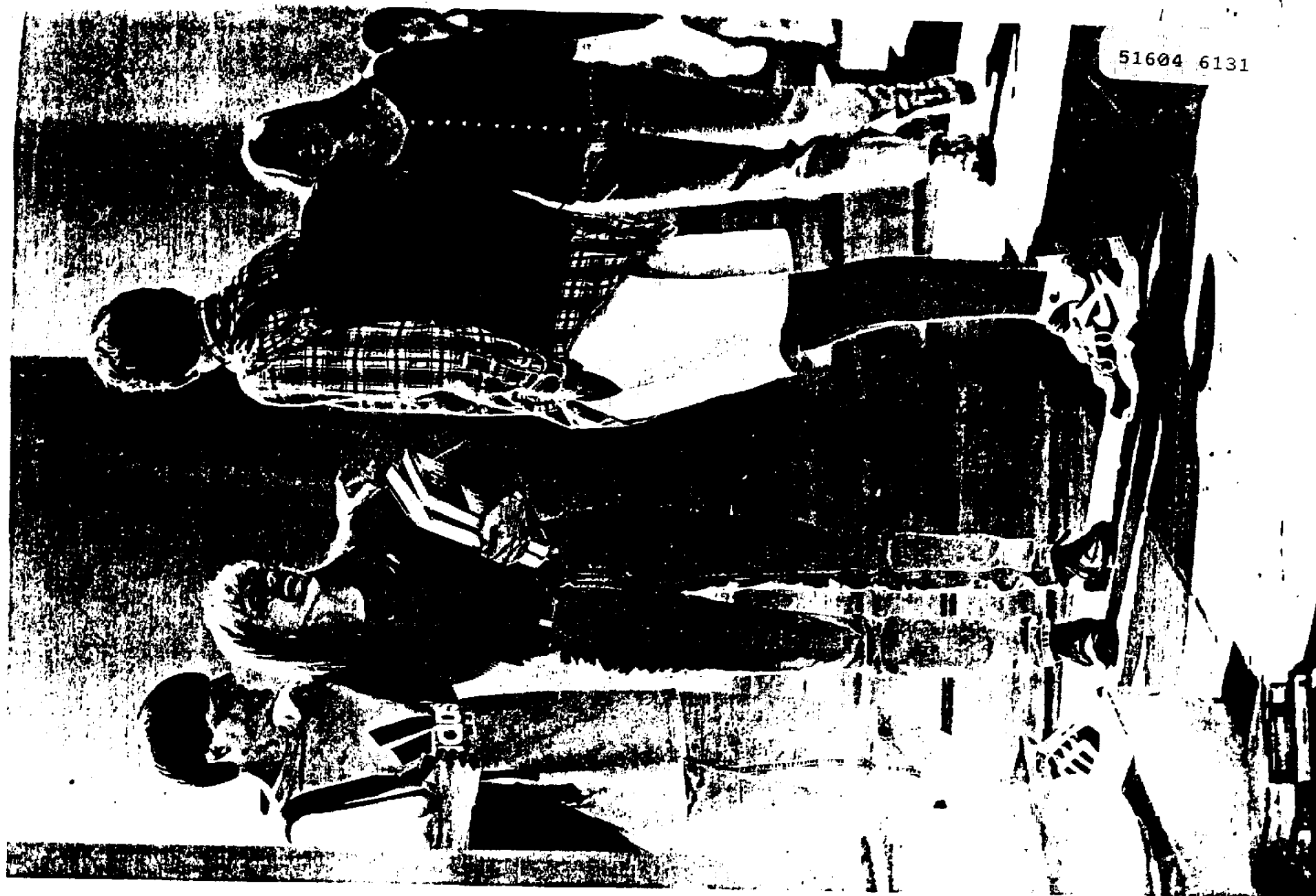
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the problem instead. Similarly, if your child is caught at inappropriate behavior, try not to resort to mere shouting or angry condemnation. Try to find the real reason for your child's actions, then work together toward a solution.

By communicating well, and being involved and interested in your child's activities, you help to build their self-confidence--the strongest antidote to peer pressure.

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# SMOKING AND YOUR CHILD

**M**any of life's activities are off limits to the young, and with good reason. Kids shouldn't drink alcohol or drive cars until they're old enough to take responsibility for the consequences. They also shouldn't smoke. Smoking is a risk factor for certain diseases and is also socially controversial. Only someone mature enough to take into account all these considerations can make a truly informed decision.

Nevertheless, some kids do smoke. During their adolescent years, young people start experimenting with many activities they've been told they shouldn't do, and smoking can be one of them.

## WHY KIDS SMOKE

A number of studies have been conducted on youth smoking, and they show that two key factors affect whether or not a child will smoke--the influence of friends and peers and the influence of the family.

The importance of peers in an adolescent's social world has already been mentioned. Because of the strong desire to fit in, they take careful notice of what their peers, and especially their friends, are doing and adopt behaviors that they think will help them be accepted. While some peer influence is positive, it also wrongly persuades some young people that negative behaviors such as smoking can provide them with a social benefit and improve their standing among their peers.

As parents, you have more influence on your children's behavior than you may feel at times. Even though they are starting to make their own decisions, they still look to you for guidance and direction. Parents can have a strong effect in reinforcing positive peer influence and diminishing negative peer influence.

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# TALKING TO YOUR CHILD ABOUT NOT SMOKING

**W**hat can you tell an adolescent who might be tempted to smoke? The good news is that there are a number of different approaches that can be very effective when used together and applied consistently. Before you sit down to talk to your child, bear in mind that adolescents respond best to a discussion that's based on reason and common sense and focuses on issues of direct interest to him or her.

## SMOKING IS A RISK FACTOR

First, you should make it clear that studies have identified smoking as a risk factor in certain diseases, such as lung cancer, heart disease, and emphysema. But you should also be aware that this may not be as effective an argument as you think. For years, your child has been warned of the potential risks of smoking by teachers, guidance counselors, coaches, and others. In fact, as a former Surgeon General said in 1979, "By the time they reach seventh grade, the vast majority of children believe smoking is dangerous to one's health." Despite this widespread awareness, an annual study conducted for the U. S. Department of Health and Human Services by the University of Michigan shows that the proportion of high school seniors who smoke every day has not changed much in several years. So it's important that you go beyond the risk factor in your discussions with your child.

## UNDERAGE SMOKING AND THE LAW

You might remind your children that it's illegal to sell tobacco products to minors. All states have set age limits for the sale of tobacco products, and all have declared it unlawful for retailers to sell cigarettes or other tobacco products to anyone under 18 (19 in Alaska, Alabama, and Utah).



Not only can retailers who sell tobacco products to minors be penalized but in some states the young person caught buying cigarettes is also subject to fines and or

community service. You can remind your child that buying tobacco can lead to trouble, for them as well as for the retailer.

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# SAY NO TO PEER PRESSURE

One of the hardest things for adolescents to do is to resist doing something their friends and peers are doing and encouraging them to do. They may know that the activity is wrong, and they may genuinely not want to take part, but the pressure to conform is intense. You can help them follow their own good instincts by teaching them a variety of ways to say "no." It will be easier for them to respond positively and confidently when they're put on the spot if they're armed with prepared responses to a range of potential situations.

Ideally, kids would simply steer clear of situations where there's a potential for trouble, and you might reinforce the fact that part of the responsibility rests with your child, that many compromising situations can be avoided altogether. However, some situations can't be avoided. You can start by pointing out the most obvious solution, which is to take a firm stand and simply say "No. I don't want to." An even stronger response is to say "No" and then walk away. But these approaches, particularly the second, require great confidence and resolve, and many kids don't want to be that abrupt with their peers or friends. There are other ways for a kid to say "No" and still remain a part of the group. After stating his or her desire not to take part, an adolescent can use one of these responses.

## **Point out possible repercussions:**

"We could get thrown out of school for this."  
Or "We could get arrested."

## **Add some humor:**

"I'd rather have a tooth filled than listen to what my mom would say." Humor is an excellent way to defuse a tense situation. You and your child can even have some fun together coming up with other responses.

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### **Suggest an alternative.**

After saying "No," change the subject or suggest another activity. "What did you think of the Super Bowl?" Or "Anybody want to go to a movie?"

### **Reverse the pressure.**

Your child might try putting on a little pressure of his own. "Hey, you know you shouldn't do that." Or "I thought you were my friend; a friend wouldn't ask that."

### **Ask a question.**

Say "Why would I want to do that?" Or "Have you thought about what would happen if we did do this?"

### **Make an excuse, even if it means stretching the truth a little.**

"I can't. A friend's coming over and I have to get home to meet him." Or "Got a guitar lesson. Gotta go."

### **Give a reason.**

Say no and give a reason for your refusal. "It's against the law." Or "Smoking will make my hair smell bad."

Go over the responses with your child, then think up different situations that your child could encounter and have him respond to them. Recognize that what works best will vary from child to child and among different peer groups, so leave it to your child to decide which approaches will work best.



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# HOW ABOUT PEER INFLUENCE

**I**n many ways peer influence is more insidious than peer pressure, and helping your child overcome it more challenging.

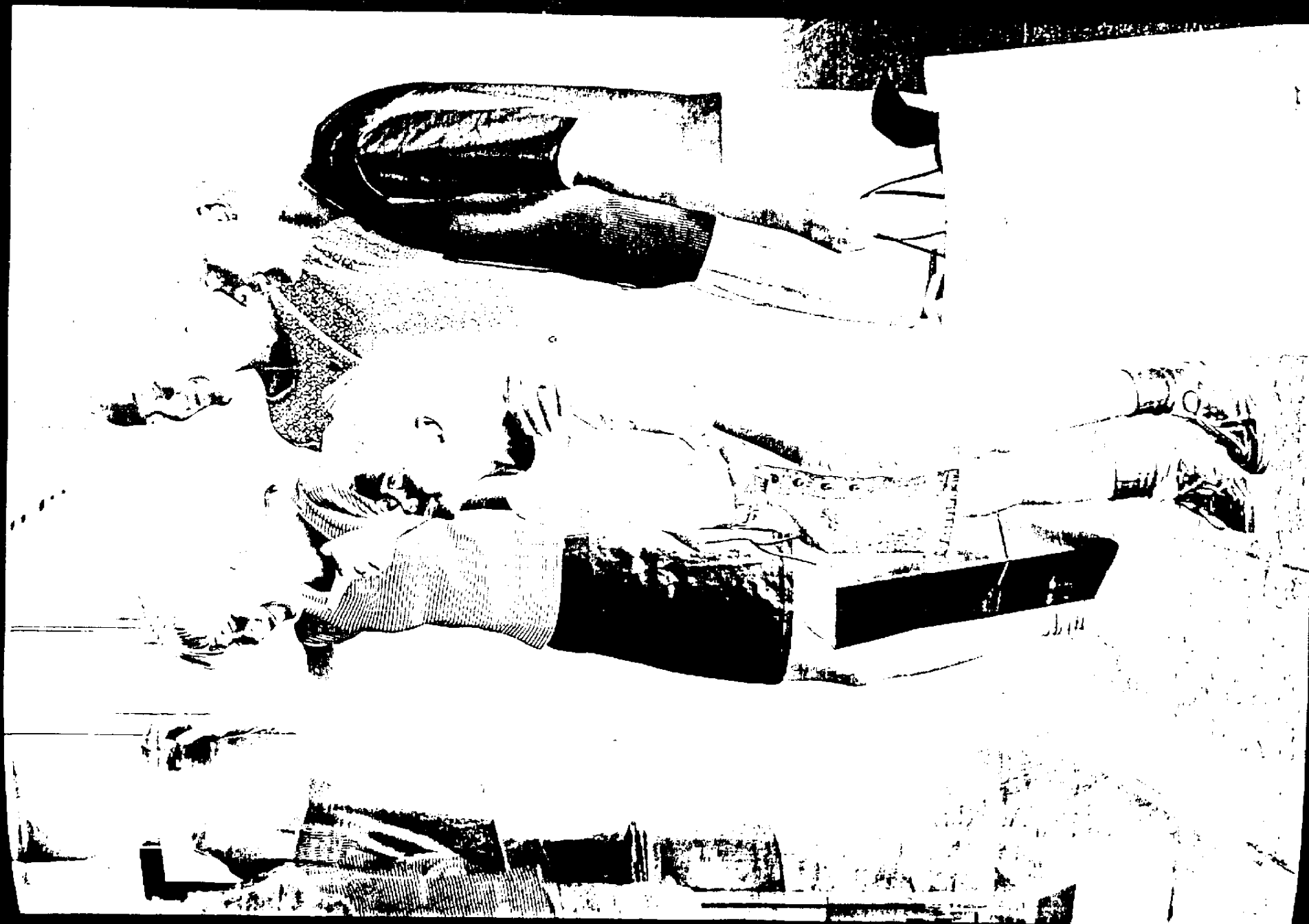
The first step is to help your child recognize the power that peer influence has over his or her life. Ask about your daughter's taste in things like music, clothing, hair styles, and entertainment. Then ask how she developed these particular tastes. It should quickly become apparent that these choices were, to a great extent, influenced by peers. It's a fact of life that we talk, dress, and act according to the standards of our friends.

You should reassure your child that there's nothing wrong with conforming to group standards and behaviors. It's perfectly normal—for adults as well as kids. Peer influence only becomes negative when, in our desire to fit in, we do something that we know deep down we shouldn't.

During this discussion you should ask your child if he or she knows anyone in school who smokes. Almost all young people know someone who does. Now ask why they think that person decided to start smoking. They may say it's because "they just wanted to" or "they were curious." Ask why they think they were curious. If you persist long enough, your child will eventually give the real reason: they wanted to look "cool" or "tough" or "grown-up," or they wanted to be "more like their friends." Then ask whether smoking really does make the person look cool or tough or grown-up. As your child thinks about this, it will become clear that smoking really didn't create the image the smoker thought it would. In fact, more often than not it has the opposite effect; a 13-year-old looks pretty silly with a cigarette in his mouth.

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# MAKING RESPONSIBLE DECISIONS

**S**moking is by no means the only important decision your child will have to face. Every day, we all make hundreds of choices--some small, others that can change the course of our lives. Every decision is different--in weight, scope and consequence. Yet it's possible to acquire a general framework for making smart and responsible decisions, a model by which to judge all of the choices we make.

Your child should learn this framework at the earliest possible age. Once he learns the process and begins applying it to his own decisions, it should eventually become second nature.

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Sit down with your child and take him through the process. You can invent a hypothetical situation where he's faced with a tough decision. Or you can use smoking as an example, or a real decision he's faced with now.

**1. Identify the issue.** Why does this decision have to be made at all? What is it that you need to decide?

**2. Gather information.** What do you know about the issue? Sometimes you have enough information, other times you don't. What more do you need to know about before making the decision? Where can you get additional information?

**3. List alternatives.** What are the possible choices? Choices aren't always so clear-cut. If the choice is between writing a paper or going to a basketball game, you might come up with a third alternative: write part of the paper and attend some of the game.

**4. Examine the consequences.** Before making a decision, really think about what the consequences might be for each alternative. Not just to you but to your friends, your parents, your school, even the community. And what consequences will it have tomorrow? Next year? Years from now? You'll have to live with the consequences. And parents, friends, teachers, and members of the community will, too.

**5. Consider feelings and values.** How do you really feel about each alternative? Do you feel absolutely comfortable with it, or does it leave a funny feeling in the pit of your stomach? How does it fit with your values and the way you think about yourself? How does it fit with your family's values and expectations? Could peer pressure or

peer influence be affecting that choice? In what way? Is peer influence leading you to a good decision or a bad one?

**6. Make the decision.** After taking all of these points into consideration, choose the best course of action.

Of course, not every decision your child makes will turn out to be the best decision. But the chances of making the right decision increase dramatically when all aspects of the situation are carefully thought through. Soon, you'll find that the decision-making process--and responsible decisions--come to your child instinctively.



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# IMPROVING COMMUNICATIONS WITH YOUR CHILD



**W**e hope this booklet has helped provide a framework for honest communication between you and your child concerning tough issues like smoking and peer influence. But before putting this advice into practice, it might be helpful to stand back and make sure the lines of communication are open. Take an inventory of your children's feelings about you and their perceptions of your relationship. Such honest give-and-take can be rewarding to both you and your child. You may discover areas where relations can be improved. And if the lines of communication are already wide open, it can help make that communication even better.

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# Parent Questionnaire

- 1) When my (son) (daughter) is upset about something, (he) (she) usually:
  - a. does not share (his) (her) feelings with me.
  - b. tells me about it.
- 2) I spend about \_\_\_\_\_ a week talking with my (son) (daughter). I think we:
  - a. should spend more time talking.
  - b. spend enough time talking.
- 3) When my (son) (daughter) is upset about something, I usually: (check the one that comes the closest)
  - a. assume that the problem isn't all that serious.
  - b. take the time to listen.
  - c. recognize that there is a problem and I am often correct about what it is.
  - d. become deeply involved – giving freely of my experience and advice.
- 4) List your (son's) (daughter's) five closest friends in order of importance.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 5) In the past few weeks, the one thing that bothered my (son) (daughter) the most was:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 6) In the past few weeks, the one thing that bothered my (son) (daughter) about *our relationship* was:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 7) Whenever I say I am proud of my (son) (daughter), it is usually because (he) (she):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 8) When I get mad at (him) (her), it is usually because (he) (she):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 9) The biggest decision my (son) (daughter) has ever made on (his) (her) own was:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 10) The toughest decision (he) (she) ever made with my help was:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# QUESTIONNAIRES



The questionnaires that follow should be answered by each of you independently. Once the questionnaires are completed, discuss each answer with your child.

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# Youth Questionnaire

- 1) When I am upset about something, I usually:
  - a. keep it to myself and don't tell anyone about how I am feeling.
  - b. tell my (mother) (father) about it.
  - c. tell my best friend about it.
- 2) I spend about \_\_\_\_\_ a week talking with my (mother) (father). I think we:
  - a. should spend more time talking.
  - b. spend enough time talking.
- 3) When something is upsetting me, my (mother) (father) usually: (check the one that comes the closest)
  - a. acts like my problems aren't all that serious.
  - b. stops whatever (she) (he) is doing to listen to me.
  - c. figures it out before I say anything.
  - d. starts lecturing me.
- 4) List your five closest friends in order of importance. Write the one word that describes why you like them next to their name, like: John - friendly.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 5) In the past few weeks, the one thing that bothered me the most was:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 6) In the past few weeks, the one thing that bothered me about my relationship with my (mother) (father) was:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 7) Whenever my (mother) (father) says (she) (he) is proud of me, it is usually because I:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 8) When my (mother) (father) gets mad at me, it is usually because I:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 9) The biggest decision I have ever made on my own was:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 10) The toughest decision I ever made with the help of my parents was:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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# CHOICES:

*Helping your child make  
the right ones*



**RIGHT  
DECISIONS  
RIGHT  
NOW**

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*A Parents' Guide to Reducing the Risk of Negative Behavior in Adolescence*

**EXHIBIT**

*Vener 43*

7.22.97

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Bob D'Alessandro  
Center for Prevention Research  
& Resource Development  
Boulder, Colorado

*Bob D'Alessandro*



# THE PARENTS' CHALLENGE

As a parent, you're naturally concerned about your child's possible involvement in such negative activities as smoking, drinking, and drug use. Today, the adolescent faces more potential pitfalls than at any time in history.



According to a recent report by the Carnegie Council on Adolescent Development, *"By age seventeen, about a quarter of all adolescents have engaged in behaviors that are harmful or dangerous to themselves and others - getting pregnant, using drugs, taking part in antisocial activity, and failing in school. Altogether, nearly half of America's adolescents are at high or moderate risk of seriously damaging their life chances."*

Like many parents, you probably feel you're caught in a balancing act. On the one hand, you want to encourage your child's independence, giving them the trust and freedom they need to grow. But at the same time, you want to carefully steer them through the minefield of adolescence and prevent them from making negative choices.

Negative behaviors are easier to prevent early on than they are to correct later, and that is what this booklet is about - **prevention**. You'll learn about the skills, attitudes and behaviors that can decrease the odds that your child will smoke, drink, use drugs or take up other undesirable behaviors. And you'll learn to apply ideas behind successful prevention programs.

Remember that, as a parent, your role is key. Adolescence is a time of enormous, rapid, often bewildering change. Of the many voices competing for your child's attention, yours is the most important.

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# ABOUT RISK FACTORS AND PROTECTIVE FACTORS

Young people who adopt negative behaviors usually share certain characteristics - traits that are apparent even before any negative behavior actually occurs. Psychologists call these "**Risk Factors**." When one or more of these are present in a child's life, the child is at heightened risk of adopting negative behaviors in the future. The more risk factors present, the higher the odds.



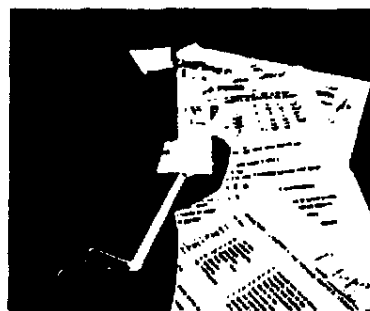
Risk factors have a counterpart in positive traits called "**Protective Factors**."

These are traits that are shared by young people who do not tend to adopt negative behaviors. Adolescents with strong protective factors are less susceptible to negative influences and will tend to choose positive activities in their place.

Risk and Protective Factors are important guideposts. Their presence or absence can serve as early warning signs of potential trouble. As a parent, you should be alert to these signs so you can intervene before more serious problems develop.

At the same time, the presence of one or two Risk Factors is not cause for panic. They do not actually cause negative behavior, and their presence does not automatically mean your child will go on to smoke, use drugs or drop out of school. Nor does the presence of Protective Factors guarantee that your child will sail through adolescence trouble-free.

Nevertheless, the presence of Risk Factors has been shown to be a reliable predictor of future problems, especially when Protective Factors are weak or absent altogether. As a parent, you can go a long way towards preventing problems later by reducing your child's Risk Factors and increasing Protective Factors.



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# Risk and Protective

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# RISK FACTORS ASSOCIATED WITH NEGATIVE BEHAVIORS

In *Adolescents at Risk*, Joy Dryfoos makes a close study of four disturbing adolescent problems - substance abuse, teen pregnancy, juvenile delinquency, and school failure or dropping out. Like many other researchers, she has identified six risk factors commonly shared by young people who engage in such behavior.

## I. Age:

The younger children are when they begin experimenting with negative behaviors, the more committed they'll become to such behaviors and the more of them they are likely to engage in.

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## 2. Education:

Poor performance in school is one of the most reliable - and correctable - predictors of negative behavior. Young people who are doing poorly in their schoolwork and have little interest in school are at much higher risk of adopting negative behaviors than those who are doing well.

## 3. Behavior/ Conduct:

The child who at an early age acts up in class, skips school, doesn't get along with other children or fights with them is more likely to become involved in problem behaviors later.

## 4. Peer Influence:

Young people can sometimes be taunted or teased by their peers into doing things they don't want to do, things they know are wrong. ("My friends smoke. They're pushing me to start. I want their respect, so I'll do it.")

And sometimes, no outside pressure is applied at all. Instead, the child observes what his or her peers are doing, and then, out of a desire to be accepted, creates pressure on himself or herself to adopt the same behaviors. ("The kids I think are 'cool' smoke. I'll start smoking so I can be like them.")

Peers have a strong influence on your child's behavior choices. If your child's friends are involved in negative behaviors, the odds are high that your child is too. This is especially true for young people who have trouble resisting peer influences.

## 5. Parental Support:

Weak bonding between parent and child is an important risk factor. Behind many adolescents with behavioral problems are parents who are either too permissive - few ground rules, unclear expectations, lax supervision, or too authoritarian - very demanding, many rules with little flexibility, and no real communication.

Between these two extremes lies the parental ideal - which the experts call **authoritative**.

Authoritative parents are those who expect a lot but don't "demand," who enforce standards and rules firmly but not rigidly, and who always leave open the lines of communication.

## 6. Neighborhood Quality:

Children living in a poverty area, or an urban, high-density community are at greater risk of adolescent negative behaviors.



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# REDUCING RISK FACTORS

As a parent, there are a number of actions you can take to reduce any risk factors present in your child or to prevent them from occurring in the first place.

## AGE:

Early intervention is key. Don't wait for minor behavioral lapses to turn into real problems. Become involved in your child's activities early on and stay involved throughout his or her adolescence.

Make clear your position on smoking and other negative behaviors from an early age. Discuss these matters frankly with your child. You'll find specific suggestions in the Targeted Prevention Messages section of this booklet.

## EDUCATIONAL SUCCESS:

Become involved in your child's education early, and stay involved through the high school years.

Stress the importance of education and your desire for your child to do well in school. Help with homework, encourage them in their studies and always make sure to praise them for successes large and small.

Address warning signs early. Teachers are usually the first to know if your child is having difficulty or is falling behind. By attending meetings and talking often with teachers, you'll be warned early on of such problems. You can work with your child's teacher to correct the problem.

## BEHAVIOR/CONDUCT:

Repeated antisocial behavior such as skipping school, fighting, or other conduct problems should be corrected early. Once again, teachers can usually tell if your child's behavior needs attention. They can also help you find people within the community to give you guidance and support.

## COUNTERING PEER INFLUENCE:

Negative peer influences are among the strongest predictors of negative behaviors. As a parent, you can take steps to counteract them. Take an active role in your child's choice of friends. The child who is surrounded from an early age by positive, well-behaved kids is less likely to be exposed to negative peer influences.

Encourage your child to attend church and take part in sports and activities at school, where he or she is likely to encounter positive influences. Coaches, scout leaders, religious leaders, and others can help encourage positive lifestyle choices. The more time kids spend with people who disapprove of negative behaviors, the less likely they'll be to experiment with them.

Get involved yourself. Attend your child's activities, games, and events. Become an adult volunteer. The stronger your participation is, the stronger your child's will be.

## PARENTAL SUPPORT:

Parents whose parenting style is either authoritarian – too heavy-handed, or permissive – too lax, should consider working to develop an

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**authoritative** style of parenting. This is the kind of parent who expects much but doesn't "demand," enforces standards firmly but not rigidly, and encourages open communication.

For information to help you assess your parenting style and for suggestions on how to adopt a more "authoritative" style, see the *Resources* section in the back of this booklet.

### **NEIGHBORHOOD QUALITY:**

You may not be able to make an immediate impact on poverty and population density, if your neighborhood has these problems, but you can take steps to provide your child with the social and emotional support network he or she needs.

You might create an informal network of "aunts and uncles" – friends, neighbors, and relatives – who can provide encouragement, guidance, and sup-

port, and can help supervise your child in your absence. You can also look into:

- *Big Brother\Big Sister* and other mentoring programs.
- Community schools offering after-school development programs.
- Community Resource Schools, which offer health and social services programs.
- Youth Service and Youth Corps programs. These provide community service programs for young people.
- Summer jobs programs.

For more information on neighborhood programs, see the *Resources* section of this booklet.

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# PROTECTIVE FACTORS

You can do more than reduce the risk factors present in your child's life. You can nurture and reinforce the traits called Protective Factors, those skills, attitudes, and beliefs common to young people who make positive lifestyle choices. The more of these traits a young person has, the less likely it is that he or she will engage in negative behaviors. These Protective Factors even seem to help young people in high risk situations overcome the odds and avoid negative behaviors. Of these, two have emerged as the most important:

1. A stable, caring and supportive relationship with at least one adult, either a parent or another dependable adult.

2. A sense of hopefulness and purpose, the belief in a bright and successful future.

The following Protective Factors are also significant.

3. The ability to develop good personal relationships.
4. The ability to set realistic goals and expectations.
5. Problem-solving skills.
6. Self-discipline.
7. Self-esteem and self-confidence.
8. A sense of being in control of one's life.
9. A sense of humor.

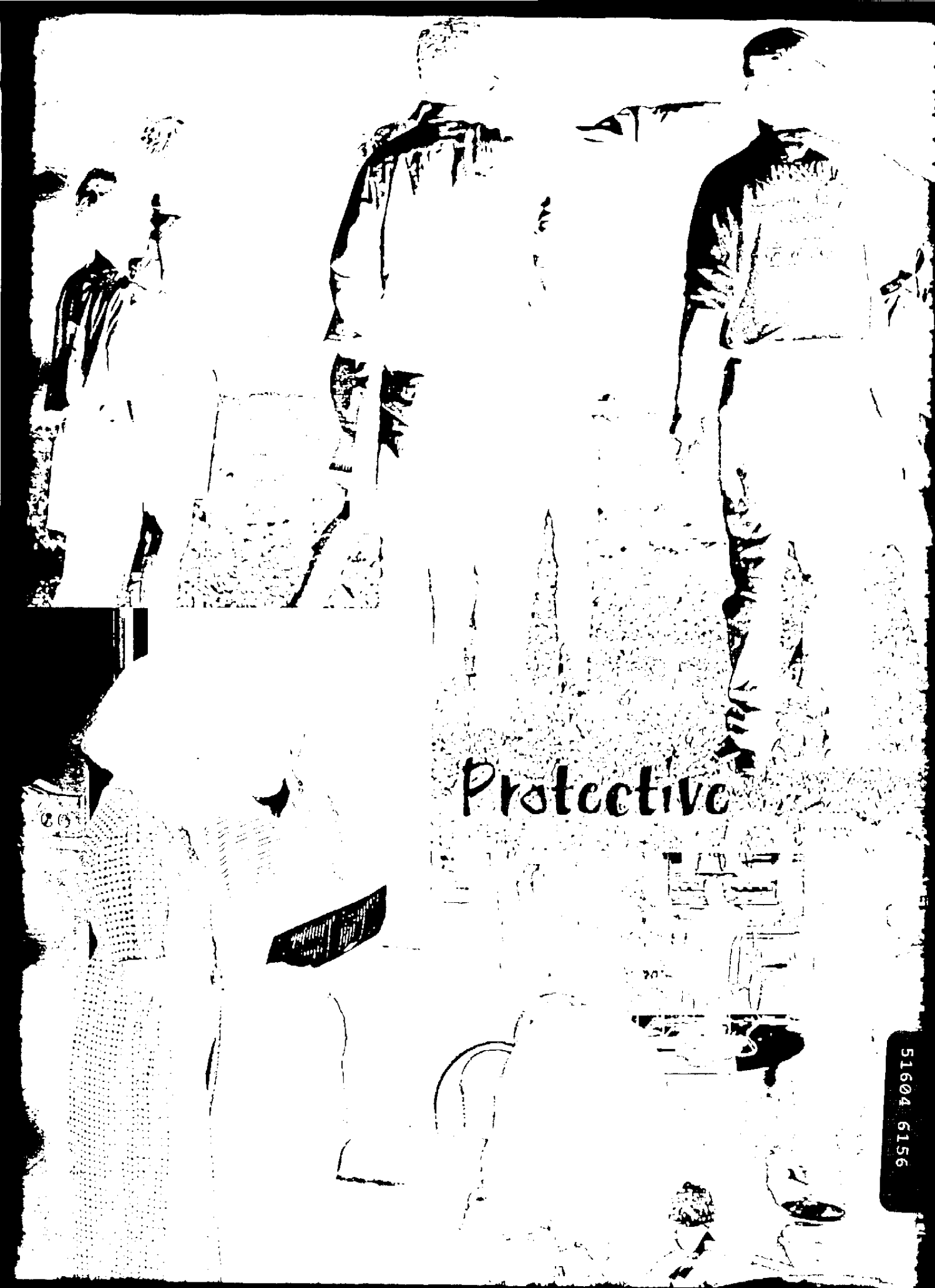
If a number of these Protective Factors are present in your child, the chances are good that he or she will avoid serious behavioral problems.

However, if your child is lacking in many of these important skills, attitudes, and beliefs, you should consider taking steps to instill them sooner rather than later. It may indicate that your child lacks the tools needed to avoid problems during adolescence.

Strengthening protective factors will not only help young people avoid negative behaviors but will improve their chances of success in all areas of their lives.

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Protective

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# STRENGTHENING PROTECTIVE FACTORS

You should begin early on to develop your child's Protective Factors, and continue strengthening them through adolescence. As your child becomes involved in friendships, sports, school projects, family projects, scouts, clubs and other activities and relationships, use these as opportunities to monitor his or her protective skills and attitudes, and to strengthen those that need work.

## STRENGTHENING THE KEY PROTECTIVE FACTORS:

### 1. Ensuring that your child has a stable, caring, and supportive relationship with at least one adult, a parent or another dependable adult.

Psychologists suggest that a strong bond with at least one adult is one of the most important protective factors. Ideally, parent and child will have formed from an early age a relationship based on mutual trust, understanding, respect, and love. Such a relationship allows the parent to fill a variety of roles – care giver, protector, counselor, teacher, mentor, disciplinarian, and cheerleader – during the child's development.

But, unfortunately, not all parent-child relationships are ideal. If yours needs shoring up, you can try the following:

- Take on projects together as a family. Taking part in meaningful and challenging family activities will help your child feel needed and important and will strengthen his or her sense of responsibility.

- Set aside a regular time each week to plan family activities, and encourage your child to suggest activities.
- Schedule family meetings to discuss family issues and resolve problems.
- Give praise where praise is due. Acknowledging children's efforts will give them the incentive to continue.
- Eat meals together regularly.
- Observe traditional family rituals, such as holidays, birthdays, and special events.

Parents who feel that their child could also benefit from a stable, supportive relationship with a dependable adult outside the family should consider a local Big Brother/Sister or mentoring program. (See the *Resources* section of this booklet.)

### 2. Helping your child develop a sense of purpose and hopefulness – the belief in a bright and successful future.

Hopefulness and purpose represent more than just a sunny attitude – they're necessary to *establishing and achieving positive goals*, a core building block



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for success and a key element in resisting negative behaviors. After all, to young people with their eyes on a goal, negative behavior isn't a temptation, it's an obstacle on the path to achievement.

From an early age, encourage your child to look toward the future with optimism and to picture a bright and positive future. Encourage him or her to look ahead to what they would like to be doing one, three, five, ten years from now. Support their positive ideas and discuss things they can do to make them happen. Help your child keep a positive outlook even when obstacles or hardships block their path.

### **STRENGTHENING OTHER IMPORTANT PROTECTIVE FACTORS:**

**3. Developing Good Relationships:** Teach your child how to choose friends wisely, how to get along with others, how to share and compromise, how to solve arguments and problems without fighting, and, in general, how to be the kind of person other people want to have as a friend and teammates.

**4. Setting Realistic Goals:** Your child will learn how to make progress in life by learning to set goals and working to reach them. The goals need to be realistic – something the child can actually accomplish. Ask them what they'd like to accomplish, help them develop a reasonable timetable, then help them achieve results. When they attain a goal, celebrate the event. As they grow older, continue to help them establish and reach new and larger goals.

**5. Problem-Solving Skills:** Children need to be taught that when faced with a problem or the need to choose a course of action, they should consider alternative solutions. They should think about the possible consequences of each alternative and select the one that's most consistent with their goals and values.

**6. Self-Discipline:** Teach your child to consider the short and long term consequences of his or her actions. Encourage them to question whether their choices will help or hinder them in reaching their goals, whether they'll be proud of their choices later or regret them. Such questions help a child look toward the future instead of seeking instant gratification.

**7. Self-Esteem and Self-Confidence:** You can enhance your children's self-esteem by helping them develop a belief in themselves and their abilities. Point out their special talents and skills. Let them know you believe in their ability to achieve results. Praise them for their successes, large and small, and help them learn from their failures without criticizing their efforts.

**8. Being in Control of One's Life:** By learning to make decisions for themselves, children can learn to influence events rather than being a victim of them. Encourage your children to make decisions appropriate for their age, and help them to learn from the natural consequences of their actions. Help them see how their actions and choices affect the events in their life.

**9. A Sense of Humor:** A sense of humor helps a person maintain balance and avoid overreacting to situations. Teach your child to see the humor in life and its events and to laugh at himself when appropriate.

The skills, attitudes, and behaviors that constitute Protective Factors need to be nurtured over time. Helping in this development is one of the most important contributions a parent can make. By doing so, you'll help your child avoid problems in adolescence. You'll also provide them with a strong foundation for achieving success in all areas of their lives.

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## TARGETED PREVENTION MESSAGES

Reducing risk factors and enhancing protective factors can go a long way toward helping your child avoid negative influences. They should be combined, however, with frank discussions about specific activities that concern you, such as smoking, drinking, or using drugs. As you talk about specifics, here are some things to keep in mind.

### Provide Factual Information

Facts are more persuasive than opinions. Before you sit down to talk with your child, prepare yourself with good information. Then discuss it with your child in a no-nonsense, straightforward way. For example, in the case of smoking, tell your child that studies have identified smoking as a risk factor in certain diseases such as lung cancer, emphysema, and heart disease. Studies show that most adolescents are already aware of the risks associated with smoking, but the message they receive at school and through the media should be reinforced at home.

You might also discuss the legal implications of smoking and the potential consequences for your child. In every state in the U.S., it's illegal for minors to buy tobacco products (under 18 in most states, under 19 in three). Also, most schools prohibit students from smoking and penalize them for doing so.

### Clearly Communicate Your Position and Expectations

It may be obvious to you that you don't want your child to smoke, drink, or adopt other negative behaviors. But you need to state this position to your child – clearly, firmly, inarguably. It's also important to supply your reasons. From an early age, your child should know exactly where you stand, and why.

Assure your child you understand it won't be easy, that they can expect pressure from their peers – but that you expect them to resist the pressure.

When talking to your child, make clear the consequences they can expect from you. For example, let them know that if you find out they are experimenting with smoking, drinking, drugs, etc., they'll be grounded or lose other privileges. On the other hand, if they refrain from such activities, their privileges and freedom will gradually increase.

If you're a parent who smokes, these discussions pose special challenges. However, you still need to

make clear that you don't want your child to smoke. You'll find specific suggestions in the booklet, "How To Talk To Your Kids About Not Smoking Even If You Do" (See the *Resources* section.)

## Help Them Say 'NO' to Peer Pressure

Resisting peer pressure is one of the greatest challenges an adolescent will face. They may know the activity is wrong and may genuinely not want to take part, but the pressure to conform is intense.

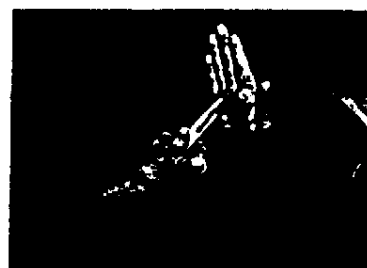
Parents can't make peer pressure go away and they can't always be there to help shape their children's decisions. But you can help them follow their own good instincts by teaching them a variety of ways to avoid giving in to direct peer pressure. Then, when they're put on the spot, it will be easier for them to resist.

You might start by pointing out the most obvious solution, which is to simply plant their feet firmly and say, "No, I don't want to do

that," and then walk away. But many kids are scared that such abrupt action will damage their relationships with their friends. If that's the case, they can say no in one of the following ways:

**Point out possible repercussions:** "We could get thrown out of school for this." Or: "My dad would go ballistic if he found out."

**Use a little humor:** "No thanks. I have a date with Julia Roberts and I hear she's down on smoking." Humor is one of the surest ways to calm a tense



situation. You and your child can even have fun together coming up with different responses.

**Suggest an alternative:** Say "no" and change the subject or suggest another activity. "Did you hear what happened to Rick last night?" Or: "Let's go check out the park."

**Reverse the pressure:** Sometimes, the best defense is a good offense. "Hey, you know I'm not into that." Or: "I thought you were my friend. A friend wouldn't hassle me."

**Ask a question:** "Why would I want to do that?" Or: "Have you thought about what would happen if we got caught?"

**Make an excuse, even if you have to make one up:** "I can't. A friend's coming over in 15 minutes, and I have to get home." Or: "I've started working out and I don't want to do that."

**Give a reason:** "No way. Cigarettes make my breath smell like an ash tray!"

Go over the responses with your child, then think

up different situations they might face and have them practice responding to them. Bear in mind that what works best will vary from person to person and among different peer groups, so leave it to your child to decide the most appropriate responses.

Finally, have your child find a buddy in his peer group. They can agree in advance to support each other's positions. It's a lot easier to stand up to peer pressure if you can count on at least one other person for support.

## FINAL WORDS

We hope this booklet has been useful in helping you guide your child's decisions in the right direction. We understand how difficult it can be in today's world. But taking an active interest in your child's affairs, and guiding them carefully through-



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out adolescence, can make an enormous difference in the decisions they make and in their future success in the world. Here are a few final suggestions.

### **Take a balanced approach**

Try not to overreact to an isolated incident or to the presence of a single risk factor. At the same time, don't ignore clear warning signs – a series of disturbing incidents or evidence of multiple risk factors. If you're unsure, confide in a teacher or counselor at your child's school.

### **The earlier you start, the better**

Risk factors are far easier to correct when you address them from the outset. The more entrenched they are, the more intractable they become. Similarly, protective factors nurtured from a young age will establish themselves deeply by adolescence.

### **Don't be afraid to ask for help**

Teachers, coaches, fellow parents, community counselors – all can provide valuable information and advice. Remember that no one individual can prevent your child from lapsing into negative behavior. It must be a team effort.

### **Be flexible – the same approach won't work for everyone**

Every family is different. Every child is unique. Don't be afraid to adapt the information in this booklet to your family's particular circumstances.

### **Use the Resources**

The resources on the pages following were carefully selected to help you apply the ideas and suggestions presented in this booklet. They include pamphlets, books, tapes, and videos you can get, and a hotline you can call. We are confident you will find them to be helpful.

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Dryfoos, J. G. (1990). *Adolescents at risk: Prevalence and prevention*. New York: Oxford University Press.

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# RESOURCES

**Developmental Research and Programs, Inc.**  
130 Nickerson, Suite 107  
Seattle, WA 98109  
(206) 286-1805

Developmental Research and Programs, Inc., has a well-established reputation for developing programs and materials to reduce risk factors in children. The following two resources were developed for parents:

1. Preparing for the Drug-free Years:  
Family Activity Book
2. Parents Who Care: A Guide for Families  
with Teens (Book and supporting video)

**Empowering People**  
1-800-456-7770

Empowering People distributes books and videotapes by H. Stephen Glenn and Jane Nelson, two highly respected experts in the areas of parenting and youth development.

Recommended resources include:

1. Developing Capable People,  
by H. Stephen Glenn (videos)
2. Developing Healthy Self-Esteem,  
by H. Stephen Glenn (videos)
3. Raising Children for Success,  
by H. Stephen Glenn and Jane Nelson (book)
4. Raising Self-Reliant Children in a Self-Indulgent  
World, by H. Stephen Glenn and Jane Nelson (book)
5. Positive Discipline, by Jane Nelson (book and video)

**The National PTA**  
330 North Wabash Avenue, Suite 2100  
Chicago, IL 60611-3690  
(312) 670-6782

The PTA makes available a variety of brochures which contain useful suggestions for parents who want to help their child succeed in school. Most are available through your State PTA office.

Recommended brochures include:

1. The Busy Parent's Guide to Involvement in Education
2. Help Your Young Child Learn at Home
3. Discipline: A Parent's Guide
4. Leading Children to Self-Esteem
5. Making Parent-Teacher Conferences  
Work for Your Student
6. Get Involved! How Parents and Families  
Can Help Their Children Do Better in School
7. Common Sense Strategies for Raising  
Alcohol & Drug-Free Children

**Search Institute**  
700 S. Third Street, Suite 210  
Minneapolis, MN 55415  
1-800-888-7828

Search Institute is highly respected among youth development professionals and educators for their research and resources to promote the positive development of children.

Recommended resources for parents include:

1. What Kids Need to Succeed: Proven Practical Ways  
to Raise Good Kids, by Peter Benson, Judy Galbraith  
and Pamela Espeland (book)
2. 240 Ideas for Building Assets in Youth,  
by Eugene Roehlkepartain (poster)
3. Building Assets in Youth: The Power of  
Positive Youth Development (video)
4. Source, a six-page newsletter which highlights the  
latest Search Institute research in a style accessible  
workers and parents.

**Points of Light Foundation**  
1737 H Street, NW  
Washington, D.C. 20006  
(202) 223-9186

The Points of Light Foundation is a non-profit organization whose mission is to engage more people more effectively in volunteer community service. The Foundation has several resources available to help parents interested in learning more about mentoring and community service opportunities for their child.

1. "How to Find a Mentor" and "How to Become a  
Mentor": Brochures which provide basic mentoring  
information.
2. Get Ready for Anything: A handbook which uses  
examples to demonstrate ways young people have  
teamed up to address important community issues.
3. Family Matters: A program designed to strengthen  
families and support family volunteerism.
4. Volunteer Center Hotline: Local Volunteer Centers  
can help parents find youth service, youth leader  
ship, mentoring programs, and other opportunities  
for youth in their community. To find out where  
your local volunteer Center is, call 1-800-59-LIGHT

**R.J. Reynolds Tobacco Company**  
P.O. Box 2959  
Winston-Salem, NC 27102

In addition to this booklet, R.J. Reynolds makes two other brochures available to parents:

1. Tobacco: Helping Your Child Say No, developed to  
help parents discourage their children from smoking  
and help them make appropriate lifestyle decisions.
2. How To Talk To Your Kids About Not Smoking, Even  
If You Do, developed especially for parents who smoke.

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#### REVIEW PANEL

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# "How To Talk To Your Kids About Not Smoking Even If You Do"



*Verner* DEP. EX. NO. 44  
FOR ID., AS OF 3-22-97

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R.J. REYNOLDS TOBACCO COMPANY



## Introduction

If you are a parent who smokes, this booklet was developed for you. It is about ways that you as a smoker can talk to your child about not smoking — a conversation that may be particularly difficult.

If you are like most smokers, you smoke because you enjoy it. And if you are like most parents, you believe as we do: **SMOKING SHOULD NOT BE PART OF GROWING UP.** So talking to your child about not smoking presents you with a unique challenge, because you will be talking about not doing something your child sees you doing every day.

You should talk to your child about not smoking whenever the time is right, no matter what his or her age. But this booklet is designed for parents with children ages 12 to 15, because various studies suggest that it is in this age range that curiosity about smoking is most likely to become experimentation.



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## Why do kids smoke?

What makes kids do the things that makes being a parent such a tough job? Why do they smoke, drink, or do other things that should not be part of growing up? Most experts agree that the key factors influencing whether or not adolescents decide to smoke are friends and parents. It's important to understand the different forms these influences can take.

## The Power Of Peer Pressure

The desire to belong or to fit in with a certain group or trend is very strong in an adolescent. Young people often observe the appearance and behavior of their friends and associates and then adopt characteristics they think will help them be better accepted by their peers — things like long hair, unusual clothing, loud music, or smoking.

Another more direct form of peer pressure is a challenge from a peer to engage in some form of behavior that may be inappropriate, such as trying a cigarette. A refusal carries the risk of being teased or taunted, and depending on the person's level of self-confidence, this type of pressure is sometimes very hard to resist.

## Desire To Appear More Mature

Many adolescents adopt behaviors they think will make them look less like a child. Some start smoking because they think it makes them appear older. For others, who may view smoking as something they realize they should not do, it may represent a way to demonstrate "independence" or defiance.

## The Smoking Parent

There is also an influence unique to children of parents who smoke. Studies show that children may be more likely to smoke if one or both of their parents smoke. This underscores the importance of your active involvement in guiding and counseling your children.

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## What should you say?

Your adolescent will be most responsive to a discussion based on reason and common sense that focuses on issues of interest to him or her. Here are some suggestions on how to approach the subject of smoking with your child.



## Smoking Is A Risk Factor

You should make it clear that studies have identified smoking as a risk factor for certain diseases. While there are many factors statistically associated with an individual's chances of developing disease — including diet, physical condition, age, gender, genetic background, occupation and stress — personal lifestyle choices, like the decision to smoke or drink, should only be made by informed adults.

The fact that smoking is associated with health issues probably won't be news to your child. For example, school systems throughout the country routinely provide non-smoking messages as part of their course work. As a former Surgeon General has stated, "By the time they reach seventh grade, the vast majority of children believe smoking is dangerous to one's health."

But despite that awareness, an annual study conducted for the U.S. Department of Health and Human Services by the University of Michigan shows that the proportion of high school seniors who smoke every day has not changed much in several years. So it is important that you discuss with your child other reasons children shouldn't smoke and ways to avoid or resist it.

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## **Be Honest About Your Own Smoking**

Kids are sharp. They can tell when you are being sincere and truthful and when you are not. A natural question your child may ask is, "Why do you smoke?" If you smoke because you enjoy smoking — as most smokers do — say so. Your child can usually tell if you are not being truthful, and there is no reason to be ashamed of giving an honest answer to an honest question. But also make it clear that you are doing so as an informed adult.

Similarly, if you really don't want to smoke and would rather quit, you should share these feelings with your child. However, if you feel this way, you should actually quit smoking. Otherwise your child may wonder if you are being honest, with yourself as well as with him or her. More than 40 million people have quit smoking in the past 30 years, and your child probably knows people who have.

## **Kids And Adults Are Different**

Your child might ask, "You smoke. Why can't I?" This is a challenging question, and you need to give an answer your child can respect and understand.

You should point out that there are a lot of things adults do that kids shouldn't. You can say, for example, that young people can become parents at 14, but they shouldn't until they are old enough to support a family and handle the responsibility. Minors can't sign

contracts to buy cars even if they can afford it, because they are not prepared to accept the responsibility and consequences. Young people shouldn't drink alcohol for the same reason. You should also mention that most states have established a minimum age for the purchase of cigarettes and that underage purchase is illegal.

Your child needs to understand that for certain lifestyle decisions an adult is better prepared to consider and understand the pros and cons and make an informed decision.

## **It's OK To Act Like A Normal Young Person**

Peer pressure is a very strong influence. However, you should let your child know that there is nothing wrong with wanting to fit in. Think about when you were that age. You'll no doubt recall examples of times when you changed your behavior to conform and become accepted. Try to avoid being overly critical of the peer-influenced trappings of youth.

The same thing is true of your child's desire for independence and self-expression. It's okay to want to demonstrate independence.

In fact, too much dependence on parents, according to experts, can be damaging to an adolescent's psychological growth and development. When your adolescent exhibits seemingly "outrageous" means of self-expression, try a little understanding, even if these

behaviors offend your personal tastes. When you take this approach, it will be easier for your child to see the differences between the positive and negative forms of expression.

The point is that there are a number of ways for your child to show he or she is part of the group and express youthful independence, and you should make it clear that it isn't necessary to start smoking to do so.



## **Smoking Doesn't Help Kids Look Older**

And what about the notion that smoking makes a kid look older? You need to understand that a child who smokes in order to look older or more mature really believes that it works. However, you can ask your child to think about a personal acquaintance of his or her same age who smokes and consider whether or not smoking really does make that person look older. As an adult, you can point out that a fourteen-year-old smoking a cigarette looks like nothing more or less than a fourteen-year-old smoking a cigarette. In fact, to many older teens as well as peers, smoking to look older may seem a childish thing to do.



## **Say "No" To Direct Peer Pressure**

Your child should be taught that peer pressure in the form of an offer or a challenge or a dare can often be resisted by the use of a simple "No" or "No, thank you." When said politely and with confidence, this approach can be very effective.

However, sometimes a simple "No" won't work. If it doesn't, another approach is to walk away and find something else to do or someone else to talk to. Removing oneself from the situation may resolve the problem.

There will be times, however, when walking away is not the right solution. Your child may be with a person or group of people he or she does not wish to leave. If so, another way to demonstrate self-confidence and fend off the pressure is to use humor. It's important that the humor be light-hearted and not confrontational. You and your child can have some fun discussing possible responses.

Recognize that what works best to resist peer pressure will vary by individual and with different peer groups. Discuss the approaches with your child, and let him or her decide which approach to use.

## What if your child is already smoking?

Perhaps you have learned that your child has already started to smoke. What can you say? Start by being calm. Your objective is communication, not confrontation. Tell your child that you know he or she is smoking and that you would like to talk about it. You may tell your child you would prefer that he or she not smoke, but you should not criticize intelligence or judgment, as this will quickly end the discussion. It is important to keep the communication lines open. In fact, your child probably assumed that you would disapprove if you learned he or she was smoking, so you should make it clear that it is because you love and care about him or her that you want to talk about it.

Ask your child why he or she smokes. If the answer is, "Because you do" or "Because my friends do," find out more. Chances are that the reason will turn out to be some kind of perceived social benefit. What you should say about smoking to a child who smokes is quite similar to what has already been discussed about what you should say to one who doesn't, except that you should add that you would like very much for him or her to stop smoking.

## Your relationship with your child is special

Remember, your biggest advantage as you discuss hard issues like smoking is the love and respect your children feel for you. They value your opinion whether they will admit it or not. They want your approval.

Recognize that growing up is hard, the lessons learned are tough, and your chances of being part of that growing experience are limited. Let the discussion about not smoking be one of them.



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## Additional Information

"How To Talk To Your Kids About Not Smoking Even If You Do" is designed to help you talk with your child about smoking.

As a parent, there are several other behaviors you may want to discuss with your child. The organizations below can provide information about other lifestyle behaviors.

### **American Council for Drug Education**

204 Monroe Street  
Suite 110  
Rockville, MD 20850  
(301) 294-0600

### **Coalition of Hispanic Health and Human Services Organizations (COSSMHO)**

1501 16th Street, NW  
Washington, DC 20036  
(202) 387-5000

### **Just Say No Foundation**

Room 210  
1777 North California Blvd.  
Walnut Creek, CA 94596  
(415) 939-6666

### **Mothers Against Drunk Driving**

National Office  
P.O. Box 541688  
Dallas, TX 75354-1688  
(214) 744-6233

### **Do It Now Foundation**

P.O. Box 27568  
Tempe, AZ 85285  
(602) 491-0393

### **Families In Action**

Drug Information Center  
Suite 204  
2296 Henderson Mill Road  
Atlanta, GA 30345  
(404) 934-6364

### **Institute on Black Chemical Abuse**

2616 Nicollet Avenue  
Minneapolis, MN 55408  
(612) 871-7878

### **National Clearinghouse for Alcohol and Drug Information**

P.O. Box 2345  
Rockville, MD 20852  
(800) 729-6686

### **National PTA**

700 N. Rush Street  
Chicago, IL 60611-2571  
(312) 787-0977

### **National Parents Resource Institute for Drug Education (PRIDE)**

50 Hurt Plaza  
Suite 210  
Atlanta, GA 30303  
(404) 577-4500

There are other organizations that can provide additional information on these and other lifestyle behaviors. The listing of an organization in this booklet does not imply that the organization endorses the information contained herein nor does it constitute an endorsement of the organization by R.J. Reynolds Tobacco Company or its Review Panel.

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Vaner DEP. EX. NO. 45  
FOR ID., AS OF 3-22-97

Helping retailers  
comply with  
Minimum Age Laws.

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Thank you for taking the time to read this brochure and to learn more about complying with minimum-age laws. Keeping cigarettes out of the hands of kids is a major goal for everyone, and we appreciate your help in working with us to accomplish it.

"Support The Law...It Works" is a training and educational program designed to help retailers and their employees comply with minimum-age laws on age-restricted products. The program focuses on the importance of complying with existing minimum-age laws for cigarettes. However, the training techniques can be applied to any age-restricted product. The program includes a range of materials to assist retailers and store clerks in this effort.

To receive any of the materials associated with this program, simply complete and mail the postage-paid order form included in the back of this brochure. All materials are available free of charge.

Thank you for helping us keep cigarettes out of the hands of kids. Remember, when we all support the law...it works!

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# Why do kids smoke?

Government research and private studies agree -- there are three major factors which influence underage smoking. Peer pressure and family influence have been shown to be the major reasons why kids start to smoke. Access to cigarettes is a contributing factor on an on-going basis. This is due, in part, to the fact that minimum-age laws aren't always followed.

Retail managers and salespersons can't do very much about peer pressure or family influence. But they can do something about underage access. Whether you're a retail manager or store clerk, police chief or a concerned adult, you can help keep kids from buying cigarettes and other age-restricted products. It's easier than you think.



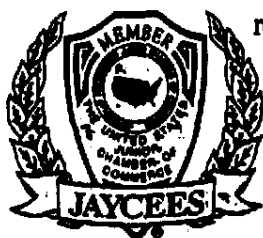
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## Why should you support the law?

All states have a minimum legal age for selling cigarettes. Why do states have such a law? Because citizens want it. They know cigarettes are adult products, just like beer and wine. And adult products shouldn't be in the hands of children.

### Simple compliance works!

Your state's minimum age is designed to keep tobacco products out of kids' hands. But responsible retailers and employees can make sure the law is understood and followed.



Education at store level can make a difference. Studies show that when retailers and the community support the law, sales to persons under the legal age can be reduced by 50% or more. That's why the tobacco industry and the major retail associations support the law. Many police departments and the United States Junior Chamber of Commerce have endorsed the program described here as an important tool for helping keep cigarettes out of the hands of kids.

## You can support the law... diplomatically!

Following minimum-age laws can be a challenge. After all, you're dealing with the public.

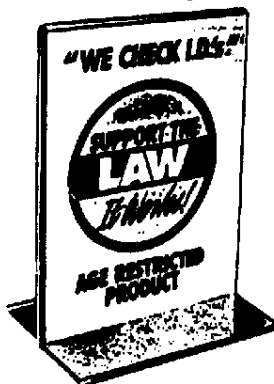
But it is the law. And in some areas, the employee breaking the law is responsible for any penalties or fines associated with the violation. Kids shouldn't be allowed to purchase tobacco products, period. So, if someone underage does try to buy cigarettes, there is one answer...no.

Of course, you want to do so courteously, without offending the person. And that's surprisingly easy. On the following pages, you'll find proven ways to support the law...diplomatically!

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## Use signs to deter underage smokers.

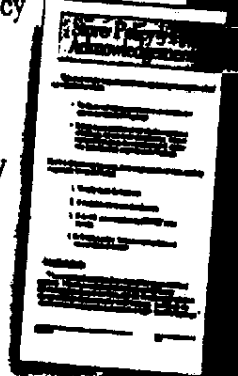
The best way to handle a problem is to avoid it in the first place. That's why many stores post signs showing support for the minimum-age law. These signs send a clear signal to all customers: "We don't sell age-restricted products, including cigarettes, to anyone under legal age".



With signs, you deter kids before they approach the cash register. Signs establish the ground rules. It's a way for the store to show its customers it is serious about compliance. It's one way to prevent cigarette sales to underage persons, while minimizing unpleasant confrontations.

## Use Acknowledgement Forms as a reminder

A good way for store clerks to show their commitment to support age-restriction laws is to have them read and sign a Store Policy Acknowledgement Form. This form clearly states the store's policy of supporting age-restriction laws, and reminds them how to professionally confirm legal age. It also allows them to formally acknowledge their commitment to support the law by signing a pledge not to sell age-restricted products to anyone under legal age. These acknowledgement forms can be ordered on the material order form included with this brochure.



51604 6176

# Ask for IDs nicely but firmly.

Sometimes a young person will see a store's minimum-age signs but ask for cigarettes anyway. In those cases, regardless of whether attempting to buy for themselves or for an adult of legal age, you must request proper identification. You may only sell cigarettes to persons



**1** Visually check to make sure the person is of proper age. Looks can be deceiving, but someone who appears younger than your state's minimum age probably is!



**2** If there's any doubt, ask for proper age identification. Explain: "We can't sell cigarettes to anyone under the legal age. So, just to make sure, I'll need to see some identification."



**3** Be polite but firm. If the person is of legal age, he or she probably won't mind showing a driver's license or other valid ID. But if the person does give you trouble, say, "I'm sorry. Our store policy says we can't sell age-restricted products to anyone without proper ID."



**4** If the person can't produce a valid ID — regardless of the reason — do not make the sale. Again, be polite. Simply say, "I'm sorry, but we require an ID. May I help you with something else?"

of proper legal age.

To make sure you're supporting the law, follow these simple steps shown below:



**5** If the person shows an ID, but it's not satisfactory, refuse the sale. Check the ID carefully, and if the birth year has been altered or the person doesn't look like the ID photo, politely acknowledge that you can't complete the sale.



**6** Be informative. The person will understand your position better if you explain it. So cite your state's law. And mention that store policy requires you to enforce it. That way, the underage person knows you're not arbitrarily refusing service.



**7** Hand out a state-law form. (see resource materials on next page). These forms provide customers a summary of your state's minimum-age law and store policy. If the person doesn't understand your refusal, just hand out one of these forms, explaining, "This will help you understand the law and our store policy."



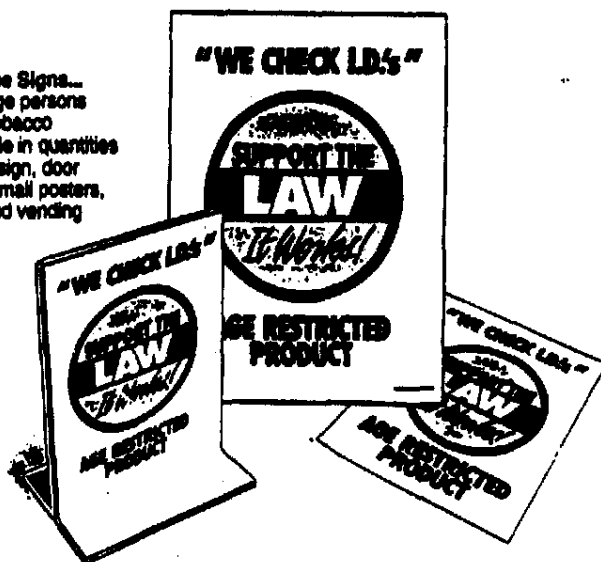
**8** What if the person still doesn't accept your refusal? Simply say, "Would you like to speak with the manager about it?" Often this will discourage an underage person from persisting.

# Take advantage of these free resources.

When it comes to following the minimum-age law, you should have the support of others. That's why we've put together these "Support the Law" materials. They represent a wide range of resources that make it easy for store clerks, as well as customers, to support the law. And every item is free.

Just complete and mail the postage-paid order form in the back of this brochure.

- **Point-of-Purchase Signs...** that deter underage persons from requesting tobacco products. Available in quantities are cash-register sign, door decal, large and small posters, ceiling dangler, and vending decal.



- **Tear-off Cards...** that briefly explain the state minimum-age law and store policy. Each pad contains about 50 cards for tearing off and sharing with customers.

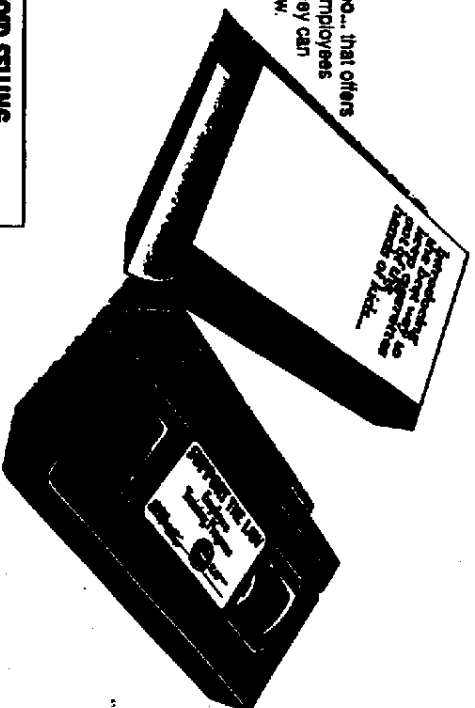


- **Buttons...** for store clerks and any other individuals to wear who want to tell others that they support the law. (2" diameter)

51604 6179



• Training Video... that offers guidance to employees about ways they can support the law.



### AVOID SELLING AGE RESTRICTED PRODUCTS TO UNDERAGE CUSTOMERS!

The store owner is responsible for ensuring the sale of age restricted products to customers who are of legal age.

It is the store owner's responsibility to ensure that the sale of age restricted products is made to a customer who is of legal age.

There is a specific law that states that the sale of age restricted products is made to a customer who is of legal age.

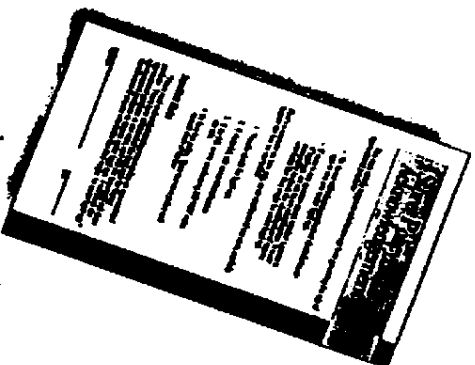
1. VERIFY CHECK FOR LEGAL AGE.
2. IF DOUBT, ASK TO BE IDENTIFICATION.
3. IF NOT Satisfied, DO NOT MAKE THE SALE.
4. BE FIRM BUT POLITE.
5. STATE THE STORE'S POLICY REGARDING SALE OF THE LAW.

TO BUY AGE RESTRICTED PRODUCTS,  
A CUSTOMER'S DATE OF BIRTH  
MUST BE ON OR BEFORE TODAY IN-

FOR LIMITED PRODUCTS: FOR ALL OTHERS, REVIEWS



• Store Policy Acknowledgment Form... for each retail employee to sign, acknowledging their understanding of store policy, and how to support the law.



• Laminated Reminder Sign... that simply outlines "Do's" and "Don'ts" for selling age-restricted products. This 16" x 10" sign can be posted in back room, break room or other areas for quick employee reference.

# RJR "Right Decisions, Right Now" Program

**YOUR BIG IDEAS ABOUT  
SMOKING ARE A LOT SMALLER  
THAN YOU THINK.**



To address the central issue of peer influence, we've developed a youth non-smoking program called "Right Decisions, Right Now." It's designed primarily to reach kids between the ages of 12 and 15 -- a time when many are struggling with peer acceptance.

The basic program message (i.e., "you don't need to smoke to fit in or express yourself") is taken straight to kids in middle and junior high

schools with wall posters and other materials.

You can help deliver this important message, too. Free posters are available for your store. (These materials do not carry any corporate identification.)

For more information on "Right Decisions, Right Now," check the program section on the order form.



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# Use this card to order free materials.

For samples or quantities of the materials shown, please complete and mail this form (no postage needed). If you are a retailer, please be sure to specify the state(s) in which you operate stores.

Fill in quantities needed in the spaces provided:

SUPPORT THE LAW	QUANTITIES		
	English	Spanish	Total
"Helping Retailers..." Brochure	_____	N/A	_____
"Support The Law" 7-minute Training Video (limit 5 per store)	_____	_____	_____
Ceiling Dangler (limit 1 per store)	_____	_____	_____
Laminated Checklist and Birth Year Reminder Card (limit 3 per store)	_____	N/A	_____
Large Poster - 18" x 25" (limit 3 per store)	_____	N/A	_____
Small Poster - 11" x 14" (limit 5 per store)	_____	_____	_____
Static Cling Decal - 5" x 7"	_____	_____	_____
Adhesive Back Decal - 5" x 7"	_____	N/A	_____
Vending Decal	_____	_____	_____
Cash Register Sign - 5" x 7" (1 per register; limit 10 per store)	_____	_____	_____
Store Policy Acknowledgement Form	_____	N/A	_____
State Law Reminder Tear Pads (limit 20 per store) Specify State(s)/City: _____	_____	N/A	_____
Buttons - 2" (limit 10 per store)	_____	N/A	_____
<b>RIGHT DECISIONS. RIGHT NOW</b>			
In-store Poster Set - 18" x 25" (1 set per store)	_____	N/A	_____
In-school Poster Program Information	_____	N/A	_____
<b>HELPING PARENTS HELP THEIR KIDS</b>			
Counter-top Display Containing 25 Booklets ("How To Talk To Your Kids...")	_____	N/A	_____

This is a: ☐ New Order ☐ Reorder

Name (please print)

Title

Company/Store

Total No. of Stores

Street Address

City/State

ZIP Code

Daytime Phone

Evening Phone

AM

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51604 6182



NO POSTAGE  
NECESSARY  
IF MAILED  
IN THE  
UNITED STATES



**BUSINESS REPLY MAIL**

FIRST-CLASS PERMIT NO. 105 WINSTON-SALEM, NC

POSTAGE WILL BE PAID BY ADDRESSEE

**Support The Law**  
**R.J. Reynolds Tobacco Company**  
**Public Affairs**  
**P.O. Box 2959**  
**Winston-Salem, NC 27199-2011**



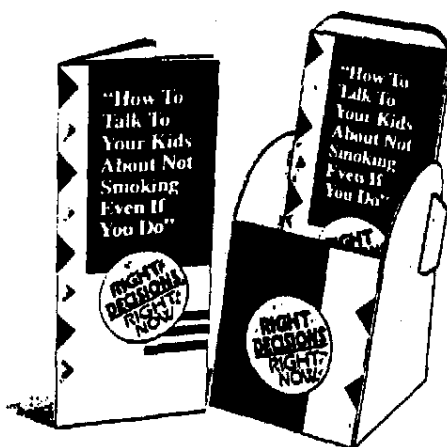
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# Helping parents help their kids

Parental guidance is another key factor in discouraging youth smoking. Research shows that kids may be more likely to smoke if one or both of their parents do. It's important that parents talk to their kids about not smoking. So we've developed

a booklet entitled "How To Talk To Your Kids About Not Smoking Even If You Do." This 4" x 9" booklet addresses the needs of parents who smoke.

You can offer this booklet free to your customers in a prepacked merchandiser designed for easy counter-top display. Simply check the section on the order form to order 25 brochures in this prepacked merchandiser.



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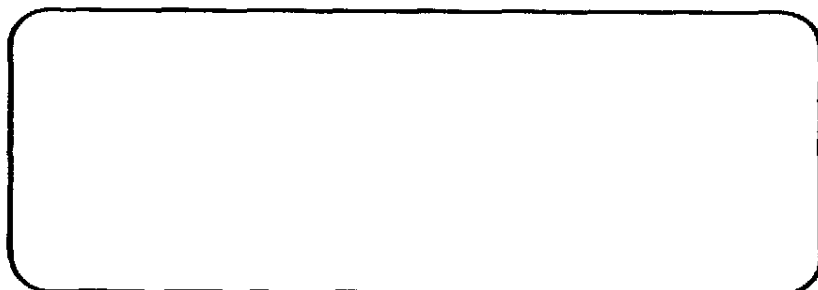
**Support The Law**

**R.J. Reynolds Tobacco Company**

**Public Affairs**

**P.O. Box 2959**

**Winston-Salem, NC 27102-2959**



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**"WE CHECK I.D.'s"**



**AGE RESTRICTED  
PRODUCT**

A cooperative effort between  
R.J. Reynolds Tobacco Company and  
the U.S. Junior Chamber of Commerce



*Venue* SEP 27, 1986  
FOR INFO. AS OF 3 22 97

51604 6186

# AVOID SELLING AGE RESTRICTED PRODUCTS TO UNDERAGE CUSTOMERS!

This store strictly supports minimum-age laws governing the sale of age-restricted products:

- We do not sell tobacco products or alcoholic beverages to anyone under legal age.
- If there is any question about whether a person is of legal age, we ask to see identification. It is our store policy to check the identification of anyone who looks like they might be under legal age.

Here's a reminder how you, as an employee, can help this store support the law:

1. VISUALLY CHECK FOR LEGAL AGE.
2. IF DOUBTFUL, ASK TO SEE IDENTIFICATION.
3. IF NOT SATISFACTORY, **DO NOT** MAKE THE SALE.
4. BE FIRM BUT POLITE.
5. STATE THE STORE'S POLICY. REMIND THEM OF THE LAW.

©1998 R.J. REYNOLDS TOBACCO CO.

**TO BUY AGE RESTRICTED PRODUCTS,  
A CUSTOMER'S DATE OF BIRTH  
MUST BE ON OR BEFORE TODAY IN:**

**FOR TOBACCO PRODUCTS**

**FOR ALCOHOLIC BEVERAGES**

*R.J. Reynolds*  
Tobacco Company



AGE RESTRICTED  
PRODUCT

51604 6187



## **BACK ROOM REMINDER SIGN**

Place this reminder sign in your store's back room, on an employee bulletin board, or in any location where it will be regularly seen by store employees.

In the two spaces provided, write (with grease pencil or erasable marker) the birth years employees should look for when checking ID's. These years should then be updated annually.

# Store Policy Acknowledgement

This store strictly supports minimum-age laws governing the sale of age-restricted products:

- We do not sell tobacco products or alcoholic beverages to anyone under legal age.
- If there is any question about whether a person is of legal age, we ask to see identification. It is our store policy to check the identification of anyone who looks like they might be under legal age.

Here's a reminder on how you, as an employee of our store, can help support the law on our behalf:

1. Visually check for legal age.
2. If doubtful, ask to see identification.
3. If the ID is not satisfactory, DO NOT make the sale.
4. Be firm but polite. State our store policy and remind them of the law.

## Store Clerk Pledge

"I have read and understand our store policy on age-restricted products. I have been informed of the legal ages for buying age-restricted products in our state, and will not knowingly sell these age-restricted products to anyone under legal age. I will check the identification of anyone who looks like they might be under legal age."

Signature \_\_\_\_\_ Date \_\_\_\_\_

Vener

47  
3-22-97

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# "WE CHECK I.D.'s"



## AGE RESTRICTED PRODUCT

51604 6190



A cooperative effort between  
R.J. Reynolds Tobacco Company and  
the U.S. Junior Chamber of Commerce



# Responsible Tobacco Retailer Program

Employees WILL CARD customers  
who appear to be underage.



Employees are trained NOT to  
sell tobacco products to minors.



Tobacco products are monitored  
by store employees.



Employees are penalized  
for selling to minors.



Members will monitor compliance.



Coalition for Responsible Tobacco Retailing

1-800-WE ID 968

fax 1-800-935-3968

51604 6191

# The PROCHAM

NEWS FROM THE COALITION FOR RESPONSIBLE TOBACCO RETAILING



read all  
about  
it...

**PAGE 2**  
Interview with "We Card"  
trainer, Rick McAllister

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a retail program

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On the Road:  
Retailers speak out

**PAGE 7**  
• How SAMSHA  
regulations will affect you  
• Kit distribution numbers

**BACK PAGE**  
Retailer Roundup

## Retailers Refuse to Sell



Roger McNeal of Allen, Okla., credits the "We Card" program with helping him end illegal tobacco purchases at his store.

Forty miles outside of McAllister, Okla., on a calm stretch of Highway 1 in Allen, Roger McNeal is living his dream. After working for other retailers for years, he bought a store of his own in March 1995.

Unfortunately, his dream didn't come without problems.

"Evidently, whoever owned the store before me didn't pay attention like I do," said McNeal of McNeal's Fast Pac. "There were quite a few young folks buying

beers and cigarettes through the drive-through window. Once I knew, I put up a notice so my customers would know that I did care whether teen-agers bought alcohol and cigarettes here."

Soon after, he was introduced to the "We Card" program materials at a trade show. Since he's been using the materials, he's had no other problems with illegal tobacco purchases at his store.

"The 'We Card' program doubly enforced what I was already doing," McNeal said. "I don't have a problem at all now. When underage customers come to the drive-through window, my clerks now ask for proper identification. The kids just drive away. They don't give us any hassle at all."

McNeal is among a growing number of retailers who are using

Continued on page 6.

"The 'We Card' training helps retailers know how to say no to illegal tobacco sales." An Interview With Trainer Rick McAllister

Rick McAllister, a former chief operating officer for a chain of convenience and grocery stores, has helped the National Association of Convenience Stores (NACS) and the Coalition for Responsible Tobacco Retailing (CRTT) design programs to prevent youth access to cigarettes. He developed the Employee Training and Instructor Guides for the "We Card" program and now serves as one of CRTT's top trainers. Recently, we interviewed McAllister to learn what he does and why it works.

**THE PROGRAM:** What did you learn from your experience writing training materials for NACS? How did that background prompt you to do things differently for "We Card?"

**MCALLISTER:** What we'd done before was strictly aimed at C-stores. We lacked cross-channel visibility. There were all these programs out there, but they didn't look the same or say the same thing. No one program was integrated enough so that consumers could recognize it wherever they

Continued on next page.



Rick McAllister developed some of the materials used in the "We Card" program.

Coalition for Responsible Tobacco Retailing  
P.O. Box 27879  
Washington, DC 20038-7879

Bus Rate  
U.S. Postage  
PAID  
Chaparral, NC  
Permit No. 3307

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# An Interview With Trainer Rick McAllister

Continued from page 1.



Thousands of retailers have participated in free training workshops to learn how to handle difficult carding situations.

went. So, "We Card" is a program everyone can use — C-stores, groceries, supermarkets, gas stations, anyone who sells cigarettes. We're starting to see the signage and buttons all over. They've replaced the whole jumble of competing materials we had before.

**THE PROGRAM:** But is that what "We Card" is all about — signs and buttons?

**MCALLISTER:** Not by a long shot! The program has two basic elements. The point-of-sale components communicate to customers that this store means business: we won't sell to minors, so don't even try. They also remind employees to uphold the law. Then there's the second big element: training. That means helping employees understand the scenarios they'll face so they'll feel comfortable and won't make mistakes.

**THE PROGRAM:** The scenarios?

**MCALLISTER:** Yes, they're the focus of our training sessions. We concentrate on three basic scenarios everyone faces. The first one is peer pressure — for instance, when you have young people behind the counter, and they're easily intimidated or wheedled. Maybe their friends are pressuring them, or their classmates are making them feel "uncool." They want to learn how to refuse the sale without suffering the negative social consequences. Management must explain to young

employees up front: "This will happen. You need to know what to say and how to deal with it." Otherwise, if the clerks aren't prepared, they'll make the sale.

**THE PROGRAM:** How do you prepare them?

**MCALLISTER:** You give them a strategy: "I'm awfully sorry, but I can't sell tobacco products to you because state law says I can't." If the clerks put the onus on the law, they're off the hook. And they can keep the customer happy too. That's key.

**THE PROGRAM:** What's the second main scenario?

**MCALLISTER:** The aggressive customer. That's the one sales people fear most. It's not a common scenario, but it does happen. You want to deal with the situation so it doesn't escalate beyond control.

**THE PROGRAM:** And if it starts to escalate?

**MCALLISTER:** We always tell sales clerks, "Make the sale." We

don't want people risking their lives over a pack of cigarettes. So they should make the sale, but then they should immediately report the whole episode to their supervisors.

**THE PROGRAM:** The third scenario?

**MCALLISTER:** Third-party sales. And there are three types of these. First, there's the innocent third party. Say, for instance, you're in the parking lot or just inside the door, and you're intercepted by kids who say they've forgotten their licenses, so would you buy them a pack of cigarettes. Meanwhile, the alert clerk has seen what's going on. The clerk says, very nicely, "Well, you probably

aren't aware of this, but state law says I can't sell tobacco products to anyone under age 18, and I think those kids who just intercepted you may be underage, so I'll have to refuse the sale." Nine times out of ten, the customer is relieved to learn he or she doesn't have to buy the cigarettes.

The second kind of third-party sale is when a child is buying on behalf of parents. Historically, that's been tolerated, but not any more. So sales clerks must say "No" in such a way that parents understand and agree. We have to retrain our customers that the rules have changed. That's where the "We Card" tip sheets come in handy. We tell sales clerks, "Just give one of these tip sheets to the kid, ask him to give it to Mom and Dad, and have the parents call me." Then, when the parents call, you explain, "Yes, I know we could always sell you cigarettes this way before, but we're not allowed to do it anymore. It's the law. If we disobey,

we could be in trouble."

**THE PROGRAM:** What's the third form the third-party sale can take?

**MCALLISTER:** A parent buys for a child. That's the most sensitive situation. The parent responds, "No one has the right to tell me how to raise my kids!" The employee must intervene and say, "Sorry, but the law says can't even sell cigarettes to you if you're going to turn around and supply them to your kids." Then the parent may repeat angrily, "Don't tell me how to bring up little Junior!" So the employee says something like, "You're absolutely right, and I hate to do this but it's the law. I've got no choice."

So you see, our major objective is to get the employees to understand the situations they'll encounter and the strategies they'll need. The crucial thing is how to refuse the sale.

**THE PROGRAM:** Can you give them any general guidelines in doing that, or is it always on a case-by-case basis?

**MCALLISTER:** There are three general guidelines. First, after you check the ID and determine that the kid's underage, you remove the product — physically — from the sale

"We teach practical tips on preventing underage tobacco sales."



Bold signage that clearly states the law helps to take the pressure off of sales clerk

area. Second, while you're removing the product, you cite the state law. This takes the burden of responsibility on the employee and places it squarely on the government. Third, you transition

Continued on page 8

# There's More To The "We Card" Program Than The Retailers.



Initially, members of the Coalition for Responsible Tobacco Retailing envisioned creating a program to prevent tobacco sales to minors that would be accepted and used across the retail spectrum. In just one year, however, the "We Card" program has become much more than a retail program. Law enforcement and health officials, wholesale distributors and outdoor advertisers are all embracing the program, helping in their own way to get the word out to retailers in their areas.

Continued on next page.

3

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# Not Just A Retail Program

Continued from page 3.

Read deButts, executive director of the Coalition, says the response is better than anyone could have hoped for.

"The overwhelming interest has allowed us to create a web of support for retailers as they work to address underage access to tobacco," deButts said. "With the help of other industries, every retailer in the country will soon have an opportunity to participate in the 'We Card' program."

Why have so many embraced the "We Card" program? Jack Advent, executive director of the Ohio Association of Tobacco and Candy Distributors, says it best:

"If we are going to, as an industry, say we don't want kids to have access to tobacco products then we have to do more than give it lip service. We have to give our best shot at making it a reality."

Law enforcement officers say they'd rather head off illegal tobacco sales than track down violators. That's why many are distributing "We Card" brochures and free kits to retailers in their areas.

Officer Thomas Fournier in Burlington, Mass., read about "We Card" in the local newspaper, ordered 40 kits and passed out 35. Fournier said the kits have been a public relations opportunity for his department.

"The kits enable us to let retailers know we aren't just out there to try and catch them selling cigarettes," Fournier said. "We want to help them. 'We Card' is a comprehensive program of education and enforcement."

The newfound relationship has allowed the Burlington officers to help retailers address problem areas.

"We found out when we were going around to the stores offering kits that in one store a young clerk was being intimidated by other kids to sell them cigarettes. We were able, with a little bit of surveillance, to make sure these kids stayed away from the store."

"'We Card' sends the message to kids that retailers are not going to tolerate underage sales and purchases."

Officer Dan Crouse of the Red Oak, Iowa, Police Department, was introduced to "We Card" at a training seminar sponsored by Iowa Crime Prevention Training.



Officer Carl Higbee works with training high school students who will present the kits to retailers.

"I'm offering the kits to retailers because they are open to new ideas and they are proactive on crime prevention," Crouse said. "The 'We Card' materials are excellent. They catch the eye very well. I think they make people coming in to buy more

aware that the business is trying to do something about underage use. I think it will make kids think twice."

In Pueblo, Colo., police have taken a different approach. School resource officer Carl Higbee lets high school students present the kits to retailers.

"We're getting the kids to go out and actually try to make their community a little better," Higbee said. "These kids are taking the kits and promoting the program, and it's working really well. The retailers have been very receptive."

The National Association of Police Organizations (NAPO), which represents 3,500 police associations and unions and more than 185,000 officers, provides members with information about "We Card" and encourages them to pass the information along to retailers.

"We got involved in the 'We Card' program knowing the importance of trying to educate children why they shouldn't

smoke," said Robert Scully, the executive director of NAPO. "'We Card' is a worthwhile program because it is proactive and preventive," he said.

"It benefits law enforcement, retail owners and the youth of America. It's a win-win situation."

## Health Departments

Several county health departments from across the country, many charged with upholding local tobacco sales regulations, are ordering "We Card" kits to share with retailers.

Judith Davidson of Jo Daviess County Health Department in Galena, Ill., first saw the "We Card" materials in a Mobil gas station.

"I walked in to get gas and said,

"That's pretty good signage you have there." It was the 'We Card' program. I liked the materials because they are blunt. I think we need to be very direct in our approach for the children."

Davidson said she plans to offer the materials to local retailers who don't have them.

Kerry Whipple of Freeport, Ill.,

wants to feature the materials in seminars offered by the Stephenson County Health Department.

"I like the kits because they are visible, especially with the bright colors and big words," she said. "They really make a point."

County health departments in Missouri, Michigan and other states have also ordered "We Card" kits.



## Outdoor Advertising

Several outdoor advertising firms with a national presence are donating billboard space to familiarize communities with the "We Card" message before consumers enter the stores.

Penn Advertising, Universal Outdoor Inc., Outdoor Systems Advertising and Eller Media, San Francisco, Calif., are donating space in cities nationwide.

Penn Advertising kicked off the "We Card" billboard program by donating outdoor advertising space in Rochester, N.Y.

"This really ties in with what retailers are doing," said Tixell Powers, general manager of Penn's Rochester division. "It adds consistency to the whole 'We Card' campaign when you see our billboards and then you see the same message on the retail counters."

According to Teresa Roelling of Universal Outdoor Inc., the "We Card" opportunity may help the industry dispel the notion that outdoor advertisers are heavy tobacco advertisers.

"About 75 to 80 percent of our business is local and that does not include tobacco advertising," Roelling said. "We wanted to show our city [Indianapolis] that we care. This is a good way to let people know we stand behind the 'We Card' program and we are against minors being sold tobacco products. We've already had some calls from people saying they like seeing the 'We Card' billboard up and they appreciate our efforts in that direction."

"We are business people with families of our own," said Ron Malinowski of Outdoor Systems Advertising in San Diego, Calif. "This is an important issue to all of us as corporate citizens and as parents with children."



Thanks to outdoor advertisers, consumers encounter the "We Card" message before they enter the stores.

## Jaycees

Representatives from the U.S. Junior Chamber of Commerce canvassed the countryside this year - in a 34-foot customized van to raise the country's awareness of the need to support state minimum-age laws.

Kelly Wills, Jaycees national president, said the organization launched "Jaycees Against Youth Smoking," or JAYS, to target youth access to tobacco products.

"Too many underage people buy cigarettes and smoke," Wills said. "The JAYS program was created to help retailers train employees to check IDs and comply with the law."

In 1996, Wills visited more than 300 cities in 48 states to draw attention to the issue. He made several stops in

each state to help local chapters kick off their own JAYS effort. Those chapters visit retailers to raise awareness.

Through JAYS, Jaycees visit retailers and ask them to sign the "U.S. Junior Chamber Responsible Merchant" pledge. By signing, retailers promise never to sell tobacco products to minors; to check for ID; to post at least one "We Card" sign; and to make sure employees understand state age restriction laws.

Stores that sign the pledge receive a certificate of recognition and "We Card" materials.

The Jaycees, with more than 2,300 chapters, have made JAYS a community service priority, Wills said.

## Wholesaler Distributors Strive to Fill in the Gaps

For several weeks, Gus Elchko, the president of Elchko Wholesale in Columbus, Ohio, put a little something extra in all his retail customers' cigarette orders - a free "We Card" kit.

Meanwhile, wholesale distributors in Indiana and Florida were leaving "We Card" brochures wherever they delivered products to their retail customers.

"It didn't matter if they ordered five cartons or fifty," Elchko said. Elchko is also president of the Ohio Association of Tobacco and Candy Distributors. "We just wanted to make sure that our customers were aware of what's going on and that they have what they need to teach their employees to card minors."

According to Susan Silver of the American Wholesale Marketers Association, it's all part of a plan to make sure that small retailers aren't left out of the "We Card" opportunity.

"Our members are independent distributors and a lot of their customers are independent mom and pop stores, independent grocery stores and smaller convenience stores that might not be in the conventional retail association network," Silver said. "Then sales forces are on the front lines, making sales calls in these stores sometimes several times a week. They can see whether or not a store has a signage program that addresses tobacco sales to minors. If the store needs one, they are right there to provide that value-added service."

In Florida where retailers face some of the toughest tobacco laws in the nation, the response has been phenomenal, said Wilson Wright, executive director of the Florida Tobacco and Candy Association.

"It's amazing when you go around Florida how many 'We Card' decals you see in store windows, signs at the point of sale and buttons on the cashier," Wright said.

The association has even included "We Card" materials in the bags of product samples they give to Florida legislators. "We've gotten a few positive comments from that. Several said they didn't know the program existed and they were delighted to know we were making an effort to get the kits in the hands of retailers."



Gus Elchko of Ohio examines "We Card" materials.

## Refusal To Sell

Continued from page 1.

the "We Card" program to stop illegal sales of tobacco to minors at stores. To date, more than 300,000 kits have been distributed nationwide and thousands of retailers have participated in "We Card" training sessions.

While many retailers say some minors still harass them when they refuse sales, they and their employees are better equipped to stand their ground.

Charli Bridges of Jim & Charli's Stuff Shop in Collinsville, Texas, says she shouldn't have to police her customers but at least the "We Card" program makes it easier.

"This ought to be the parents' job," Bridges said. "With the 'We Card' materials, they [minors] still try to buy it, but I have my little calendar over here and we just check their ages out. Some just grin and go on. Others stomp out of here muttering and carrying on."

Mel Sellar, owner of Cedar Hill Grocery in Gilbertsville, Ky., agreed. He's encountered minors who present fake identification and others who claim to have left their drivers licenses at home.

"We get kids in here who look 35 but are only 16," Sellar said. "I tell my clerks if you have any doubts at all to go ahead and card them. I've found that customers who are over 18 will have identification in their hands because they've been carded before. The ones who are under 18 say they've left it at home, but I tell them that is not a good excuse. They know they can't get cigarettes from us."

The bright "We Card" signage with its clear message, "Under 18 No Tobacco We Card" serves as a reinforcement for retailers who are trying to uphold the law.

Steve Hosclaw of Avenue Cut Rate in Reading, Pa., said he now wants to concentrate on educating parents near his store.

Many don't understand why they can no longer send their underage children in to buy cigarettes.

"I knew these six, seven and eight-year-olds weren't smoking back then," Hosclaw said. "I did their parents a favor. But then the kids grew up and started smoking and tried to say they were buying cigarettes for their parents. It was wrong for me to sell to them back then. Even their parents call now and ask why I won't sell their kids cigarettes any more. I say it's illegal and I'm not going to break the law for you."

The bright "We Card" signage with its clear message, "Under 18 No Tobacco We Card" serves as a reinforcement for retailers who are trying to uphold the law.

Some retailers say they've implemented other strategies along with the "We Card" materials. For example, McNeal, of Allen, Okla., said he no longer hires underage clerks because they are more susceptible to peer pressure and intimidation.

"I think that was part of the problem," he said. "The previous owner had high school students working here but I've upped the age of my employees."

Diana Chagnon, the owner of Corner Mini Mart in West

Newton, Mass., said she has threatened to call the police on minors who try to leave money on the counter and walk out of the store with cigarettes.

"I've told them if you want cigarettes go some place else," Chagnon said. "Don't make my job difficult."

Chagnon said the "We Card" materials have helped her combat underage sales. In fact, her employees passed nine consecutive compliance checks at her store. That's why she's fighting "city hall" to protest a tenth check in which a 6'2 male was sent in to buy cigarettes.

"My employee was 6'1 and 24 years old," Chagnon said. "He knows about carding but he looked at this kid as an equal. In fact, about 60 percent of the stores that day sold to the same minor."

Chagnon took her case to the mayor and to the newspaper. While officials agreed that the minor they used in those compliance checks was a poor choice, they would not revoke the citation she received. Chagnon says she is even more aggressive in her carding efforts now. She gives cash incentives to employees who pass compliance checks.



Minors who come to the McNeal's drive-through window drive on without tobacco products.

"It's better than paying the fine," she said. "I told my employees I can't afford the fines. You have to be on your toes or I will have to let you go."

## On the Road...

CRRP The Program was defined with comments from retailers who described how the "We Card" materials have benefited them. Here are a few of their comments.

"We will not sell without proper I.D. When they [minors] come plain, we can then point to the door with the sign which they just walked through and point to the cashier sign. They then realize we mean what we advertise and it's the law."

- Julia Rogowski, Pikes Creek Beverage, Hunlock Creek, Pa.

"After we started using the program the rate of underage attempts at buying dropped by 80% or more."

- Jim Mitchell, Edinburg Gasoline Stations, Inc., Cadiz, Ky.

"I am the Safe and Drug Free Schools' Coordinator. My advisory council was impressed with the material. Collstar was the first in the area to begin using it. We are trying to fight the problem."

- Judy Tenhill, Moberly Public Schools, Moberly, Mo.

"Great program. Seems to be more effective than anything the federal government has said."

- Linda Castle, Davis Grocery, Slick, Ky.

"I have two drive-through cigarette stores. Kids see the 'We Card' sign and also, if you weren't born on this day... They usually drive on because they know we card. Our older customers get a kick out of it. We card them. Some even offered us quarters for the 'compliment.' 'We Card' has been great for our business."

- Danny Simpson, Bridge Tobacco Shop, Rustell, Ky.

# The SAMHSA Regulations:

## One of the Most Important Reasons to Take Advantage of Free "We Card" Materials

On January 19, 1996 the U.S. Department of Health and Human Services (HHS) issued new regulations to implement the 1992 Synar Amendment. The Synar Amendment requires states to enact laws prohibiting the sale of tobacco to minors in order to receive block grants from the Substance Abuse and Mental Health Services Administration (SAMHSA). To be eligible to receive these federal funds, states must:

- Have in effect a law prohibiting the sale of tobacco to individuals under the age of 18.
- Enforce the law "in a manner that can reasonably be expected" to reduce youth access to tobacco.
- Conduct random, unannounced inspections.
- Submit a report each year to the Secretary of HHS setting forth the state's plan for enforcement along with a summary of past accomplishments.

Within several years, all states must achieve a compliance rate of 80%. That is, minors must not be able to buy tobacco products

over-the-counter or from vending machines more than 20% of the time. In addition, states must meet annual interim compliance goals that they set for themselves. If these goals are not met, the Secretary of HHS will withhold up to 40% of that state's block grant for that year.

In order to accurately project these interim goals, states will be conducting "random, unannounced inspections" – or "stings" – of retailers during fiscal year 1996 to determine a baseline compliance figure. States that have lower compliance rates, where minors can more easily buy tobacco from retailers, will be allowed more time to achieve the 80% "no sale" requirement.

The governor of each state will determine the most appropriate agency or group – public or private – to carry out the inspections. However, the SAMHSA regulations stress that the unannounced inspections should be conducted in a "fair, consistent, unbiased, planned manner" and protect retailers against entrapment.

Widespread and consistent use of "We Card" training materials is an integral part of achieving these compliance goals. Don't cause your state to lose federal funds: make sure YOUR clerks know the law!



## Coalition for Responsible Tobacco Retailing Kit Distribution

Order and Kit Distribution Analysis

State	Qty of kits ordered	State	Qty of kits ordered	State	Qty of kits ordered
Alaska	336	Kentucky	6,680	New York	20,661
Alabama	7,770	Louisiana	4,297	Ohio	12,237
Arkansas	3,556	Massachusetts	7,245	Oklahoma	4,282
Arizona	3,768	Maryland	6,338	Oregon	3,284
California	29,230	Maine	1,935	Pennsylvania	18,179
Colorado	3,693	Michigan	14,221	Rhode Island	1,920
Connecticut	3,117	Minnesota	12,569	South Carolina	4,362
District of Columbia	293	Missouri	6,464	South Dakota	1,090
Delaware	1,152	Mississippi	3,364	Tennessee	6,755
Florida	16,871	Montana	2,019	Texas	16,729
Georgia	8,190	North Carolina	13,171	Utah	1,601
Hawaii	957	North Dakota	1,536	Virginia	6,539
Iowa	5,019	Nebraska	2,975	Vermont	2,255
Idaho	1,762	New Hampshire	2,494	Washington	4,438
Illinois	12,375	New Jersey	11,626	Wisconsin	5,405
Indiana	7,697	New Mexico	1,685	West Virginia	2,566
Kansas	3,659	Nevada	4,457	Wyoming	796
				Totals	325,837

# Training Roundup

"The more we educate sales people about the various scenarios they'll encounter, the better they can handle those situations safely and professionally."

That's the value of "We Card" training, says Doug DuBois, education director for the Texas Petroleum and Convenience Store Association (TPCSA). This year, he says, the Association's theme is "education." And "We Card" fits right in.

Retail clerks must often "think on their feet," he says. "They're on the spot. An adult may come in and ask for four different brands. He's not going to smoke them all himself. If kids are hanging out nearby, it's possible they've asked this guy to buy for them. 'We Card' training helps the sales clerk recognize what's happening and deal with it."

Employees are grateful for this guidance, he says. And so are store owners.

The TPCSA worked with the Coalition for Responsible Tobacco Retailing on the first "We Card" training session in March 1996. More than 150

store managers traveled to McAllen, Texas, for the seminar. Another 500 owners, managers and employees attended subsequent sessions across the state. Many now use "We Card" tools to head off illegal sales

"Texas retailers are committed to supporting the law and doing all they can to prevent youth access," says DuBois. "Now we just need cooperation from cities, towns and parents reinforcing that minors should not purchase, possess or smoke cigarettes."

Kate Zachech, a former National Association of Convenience Stores training director, found the same level of commitment at a series of Ohio seminars last August. And Illinois trainer Rob Karr reports his state's merchants are just as receptive.

As a government relations director at the Illinois Retail Merchants Association (IRMA), Karr works with a coalition including the Illinois Liquor Control Commission, the Illinois State Police and the state Alcoholism and Substance Abuse and Public Health departments. Together, IRMA and its partners sponsored training sessions statewide in October.

Karr and his associates focused on "training the trainers"—owners and managers who in turn train their sales clerks. Attendees quickly embraced "We Card," especially kit components like store signs, tip sheets and calendars. "These tools give clerks a better chance of handling the sales situation well and avoiding a potentially explosive outcome," says Karr.



The "We Card" program's variety of components works well for all.

## An Interview With Trainer Rick McAllister

Continued from page 2.

your customer from rejection to respect. How you deal with the customer's sense of rejection largely determines what happens next. You can get embroiled in a confrontation. Or you can win the customer over as a loyal, long-term patron.

**THE PROGRAM:** How do you make that transition?

**MCALLISTER:** "Gosh," you could say. "I'm really sorry I can't make this sale. I don't want to lose you as a customer. Is there something else I can do for you? Can I ring up your snacks or this milk and bread you have here?" Treat the customer with honor, allay his sense of embarrassment, and you'll reduce the possibility of an emotional blowout.

**THE PROGRAM:** How is this "situational" training approach working?

**MCALLISTER:** The program in total, with both its main aspects of point-of-sale and training, is working. In a substantial number of cities, counties and states, the authorities themselves are impressed, and they readily embrace the "We Card" concept. The Jaycees, some of the state people charged with enforcing the Synar Amendment, even the health departments—all have requested our kits, and many have jumped on board. We just need to get more retailers on board... and specifically get more to attend the training events.

We're aiming for 100% participation across the board, and we think that's a realistic goal, because the program is flexible. You don't have to use everything in the "We Card" kit. Just pick whatever parts of the program you want to use in your store. We hope retail people out there will grasp the seriousness of the issue and then invest time and effort into using the materials. That's the only way "We Card" will work nationwide.

**FREE  
Materials**

**Inform your customers of the FDA  
regulations' "carding" requirements**

**FREE  
Materials**

**O R D E R F O R M**

**Order  
Quantity**

\_\_\_\_\_ **Tearpad:** A Tearpad of 25 sheets that retailers can use to  
inform customers of the FDA "carding" requirements.

\_\_\_\_\_ **Counter Sign:** A counter sign alerting customers to the FDA  
"carding" requirements.

Manager/Store Contact Name: \_\_\_\_\_

Business Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Fax: ( \_\_\_\_\_ ) \_\_\_\_\_

*Courtesy of the Coalition for Responsible Tobacco Retailing*

**Mail this Order Form or Call 1-800-WE ID 968 or Fax: 1-800-935-3968**

51604 6200

# "WE CARD" ORDER FORM

1

SPECIFY FOR AGE OF PURCHASE MATERIALS:

☐ Tobacco ☐ Tobacco/Alcohol

## HIT ORDERING

2

☐ Please send me \_\_\_\_\_ (qty) "We Card" Kits

☐ Please send me \_\_\_\_\_ (qty) **1997 Renewal Kits**  
(update your 1996 materials to the current year)

## TYPE OF HIT

3

☐ Convenience Store Kit

☐ Grocery/Mass Retail Kit

*Training videos must be ordered separately.*

### CONVENIENCE STORE KIT

2 Window/Door Decals  
2 Counter Signs  
1 Calendar  
4 Age of Purchase Stickers  
1 Breakroom Poster  
2 Employee Training Workbooks

### GROCERY STORE KIT

2 Window/Door Decals  
4 Age of Purchase Stickers  
1 Breakroom Poster  
2 Employee Training Workbooks

## ADDITIONAL ITEMS AVAILABLE

PLEASE INDICATE QUANTITY

<input type="checkbox"/> "We Card" Pins	<input type="checkbox"/> "We Card" Counter Signs
<input type="checkbox"/> "We Card" Window/Door Decals	<input type="checkbox"/> "We Card" Tearsheet Pads
<input type="checkbox"/> Age of Purchase Calendars (shows year)	<input type="checkbox"/> Breakroom Reminder Posters
<input type="checkbox"/> Age of Purchase Stickers (shows year)	<input type="checkbox"/> Training Video Cassettes
	<input type="checkbox"/> Employee Training Workbooks

4

Manager/Store Contact Name: \_\_\_\_\_

Business Name: \_\_\_\_\_

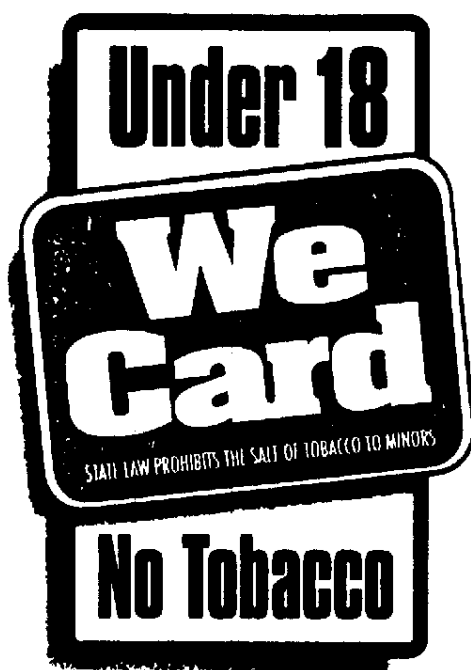
Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

51604 6201

STATE LAW PROHIBITS THE SALE OF TOBACCO TO MINORS.



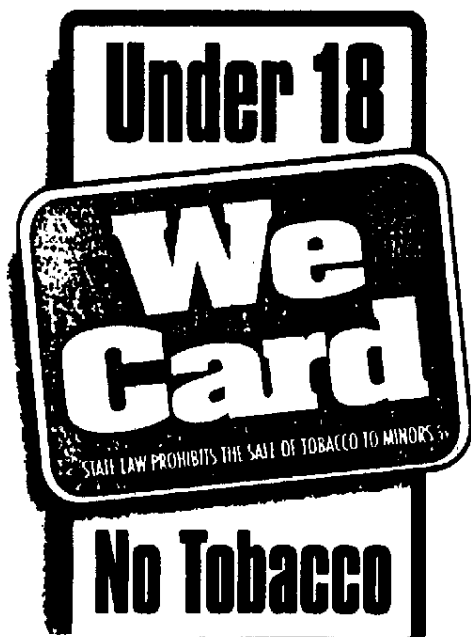
IF YOU WEREN'T BORN  
BEFORE TODAY'S DATE IN

**1979**

**YOU CAN'T BUY  
TOBACCO PRODUCTS!**

STB 2.1/87

STATE LAW PROHIBITS THE SALE OF TOBACCO TO MINORS.



IF YOU WEREN'T BORN  
BEFORE TODAY'S DATE IN

**1979**

**YOU CAN'T BUY  
TOBACCO PRODUCTS!**

51604 6202

***Please have your ID ready***

Effective February 28, 1997,  
we are required under Food  
and Drug Administration  
(FDA) regulations to verify  
age through a photo ID that  
includes date of birth from  
any person buying cigarettes  
or smokeless tobacco who is  
26 years of age or younger.



***We regret any inconvenience***

Courtesy of the Coalition For Responsible Tobacco Retailing

51604 6203



**Employee Guide To**

**Prohibit Tobacco**

**Sale**

**Minors**

DISTRICT OF COLUMBIA

**Under 18**

**We  
Card**

STATE LAW PROHIBITS THE SALE OF TOBACCO TO MINORS

**No Tobacco**

51604 6204

# Responsible Tobacco Retailer Program

This company participates in the Responsible Tobacco Retailer Program. The program's training materials and signs help retailers ensure that tobacco products are not sold to minors. The program's voluntary guidelines are listed below.

Employees *WILL CARD* customers  
who appear to be underage.



Employees are trained *NOT* to sell  
tobacco products to minors.



Tobacco products are monitored  
by store employees.



Employees are penalized for  
selling to minors.



Members will monitor compliance.

Coalition for Responsible Tobacco Retailing  
1-800-WE ID 968  
fax 1-800-935-3968

51604 6205



**To our Valued Customer,**

Effective February 28, 1997, we are required under Food and Drug Administration (FDA) regulations to verify age through a photo ID that includes date of birth from any person buying cigarettes or smokeless tobacco who is 26 years of age or younger.

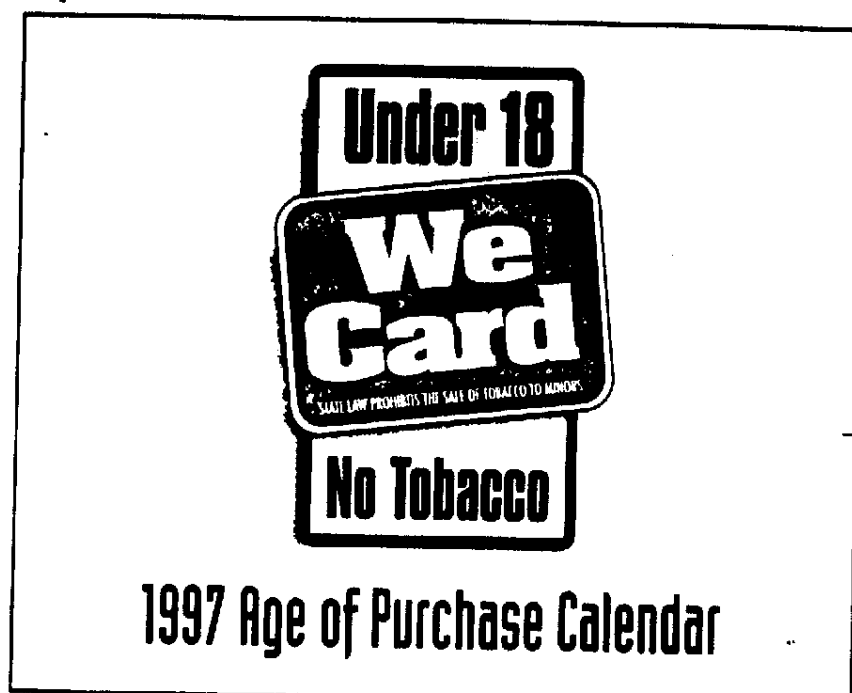
If you have questions or comments, contact:  
Office of Policy (HF-26), Food and Drug  
Administration, 5600 Fishers Lane,  
Rockville, MD 20857.



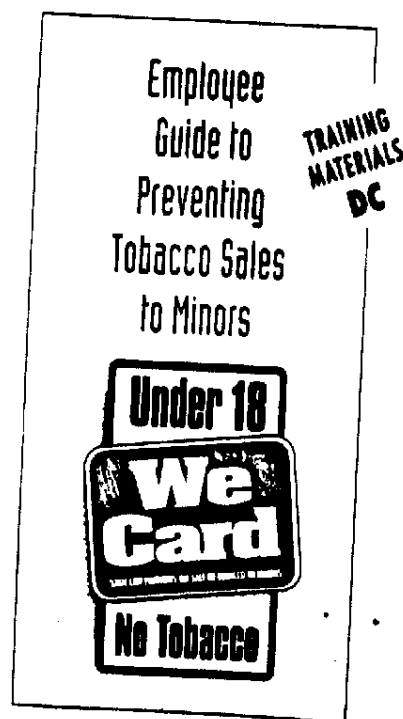
**WE REGRET ANY INCONVENIENCE**

Courtesy of the Coalition For Responsible Tobacco Retailing

51604 6206



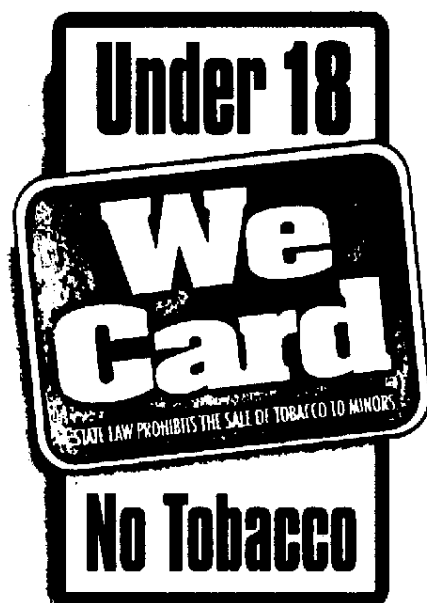
CT8.2.11/96



51604 6207

**Employee  
Guide to  
Preventing  
Tobacco Sales  
to Minors**

**TRAINING  
MATERIALS  
DC**



VC8.1.12/95

51604 6208

51604 6209



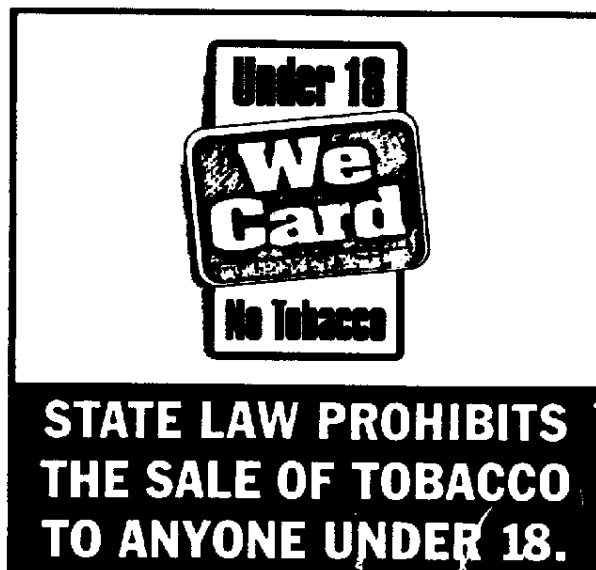
**TO AVOID SELLING TOBACCO  
PRODUCTS TO UNDERAGE CUSTOMERS:**

- 1. VISUALLY CHECK FOR LEGAL AGE.**
- 2. IF IN DOUBT, ASK FOR IDENTIFICATION.**
- 3. IF NOT SATISFACTORY, DO NOT MAKE THE SALE.**
- 4. BE FIRM, BUT POLITE.**
- 5. STATE THE STORE'S POLICY.**
- 6. REMIND CUSTOMER OF STATE LAW.**

**UNDER 18?  
NO TOBACCO!**

51604 6210

TP8 1.7/96



COALITION FOR  
RESPONSIBLE  
TOBACCO RETAILING



1-800-WE ID 968  
FAX: 1-800-935-3968



Coalition for Responsible Tobacco Retailing  
P.O. Box 27879  
Washington, D.C. 20039-7879

☐-X28-805

51604 6212



## IN THE CHANCERY COURT OF JACKSON COUNTY, MISSISSIPPI

IN RE MIKE MOORE, ATTORNEY GENERAL EX REL,  
STATE OF MISSISSIPPI TOBACCO LITIGATION

CAUSE NO. 94-1429

**DEFENDANTS' NOTICE OF DEPOSITION: MR. KEVIN VERNER**

PLEASE TAKE NOTICE that pursuant to the Mississippi Rules of Civil Procedure, Defendants will take the videographic deposition of Mr. Kevin Verner ("Mr. Verner") defendants' expert witness, commencing at 1:00 p.m. on Saturday, March 22, 1997 at the offices of Jones, Day, Reavis & Pogue, 77 West Wacker Drive, Chicago, Illinois or at another location proposed by plaintiff.

The above deposition will be taken upon oral examination pursuant to the Mississippi Rules of Civil Procedure. You are invited to attend and take part as you deem necessary and proper.

Dated: March 20, 1997  
Pascagoula, Mississippi

Respectfully submitted,

By: COLINGO, WILLIAMS, HEIDELBERG,  
STEINBERGER & McELHANEY

By: Joe R. Colingo/gdc  
Joe R. Colingo  
LIAISON COUNSEL FOR DEFENDANTS

COLINGO, WILLIAMS, HEIDELBERG,  
STEINBERGER & McELHANEY  
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Pascagoula, Mississippi 39568

51604 6213

Verner 51  
3-22-97

**C E R T I F I C A T E**

I, Joe R. Colingo, of the law firm of Colingo, Williams, Heidelberg, Steinberger & McElhaney, PA, do hereby certify that I have this day forwarded the above and foregoing DEFENDANTS' NOTICE OF DEPOSITION: Kevin Verner to the following counsel of record:

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TOBACCO INSTITUTENATIONAL AND LOCAL COUNSEL:

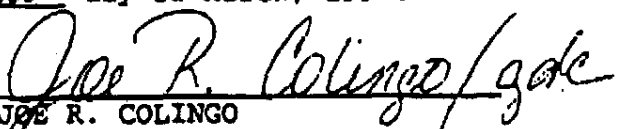
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E. Brooke Ferris, III, Esq.  
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BULLOCK & FERRIS  
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414 West Oak Street  
Laurel, MS 39441-1409  
Telephone: 601-649-8611  
Facsimile: 601-649-6062

SO CERTIFIED, this the 20<sup>th</sup> day of March, 1997.

  
JOE R. COLINGO  
Counsel for Defendant  
R.J. Reynolds Tobacco Company

March 20, 1997

IN THE CIRCUIT COURT OF THE 15th  
JUDICIAL CIRCUIT IN AND FOR THE COUNTY  
OF PALM BEACH, FLORIDA

THE STATE OF FLORIDA, et al.	)	CIVIL DIVISION
	)	
Plaintiffs,	)	CASE NO. CL95-1466AH
	)	
v.	)	
	)	
THE AMERICAN TOBACCO	)	
COMPANY, et al.,	)	
et al.	)	
	)	
Defendants.	)	

**CROSS-NOTICE OF TAKING DEPOSITION**

TO: All Counsel on attached service list.

PLEASE TAKE NOTICE that the undersigned attorneys will take the deposition of:

NAME: Kevin Verner  
DATE/TIME: Saturday, March 22, 1997 @ 1:00 p.m.  
PLACE: Jones, Day, Reavis & Pogue  
77 West Wacker Drive  
Chicago, Illinois

Upon oral examination before Court Reporters, or any other Notary Public or officer authorized by law to take depositions in the State of Illinois. Said deposition was originally noticed in In Re Mike Moore, Attorney General Ex Rel., State of Mississippi Tobacco Litigation. Cause No.: 94-1429, which is pending in the Chancery Court of Jackson County, Mississippi. The deposition is being taken for the purpose of discovery, for use at trial, or for such other purposes, as are permitted under the applicable and governing rules.

51604 6219

Verner 52  
3-22-97




**CERTIFICATE OF SERVICE**

WE CERTIFY that a true and correct copy of the foregoing Cross-Notice of Taking Deposition of Kevin Verner was faxed and mailed to all counsel of record on the attached service list on this 21st day of March, 1997.

POPHAM, HAIK, SCHNOBRICH &  
KAUFMAN, LTD.  
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Miami, Florida 33131  
Telephone: (305) 530-0050

By:

  
DOUGLAS J. CHUMBLEY  
Florida Bar No.: 356301  
AMY FURNESS  
Florida Bar No. 0034355

R. Dal Burton  
Paul Greco  
JONES, DAY, REAVIS & POGUE  
3500 One Peachtree Center  
303 Peachtree Street, N.E.  
Atlanta, Georgia 30308-3242

Robert F. McDermott  
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1450 G Street, N.W.  
Washington, D.C. 20005-2088

Counsel for R.J. Reynolds Tobacco Company

1134078.1

*State of Florida, et al. v. The American Tobacco Company, et al.*  
Case No. CL 95-1466 AH  
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Telephone: (904) 356-4100  
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1134078.1

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CLEVELAND NEW YORK  
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FRANKFURT RIYADH  
GENEVA TAIPEI  
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WASHINGTON, D.C. 20005-2088

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CABLE: ATTORNEYS WASHINGTON  
FACSIMILE: 202-737-2832  
WRITER'S DIRECT NUMBER

7:55:am  
182310\_1

(202) 879-3991

February 19, 1997

VIA TELECOPY

Ann Ritter, Esq.  
Ness, Motley, Loadholt,  
Richardson & Poole  
151 Meeting Street, Suite 600  
Charleston, SC 29402

Charles Mikhail, Esq.  
Scruggs, Millette, Lawson,  
Bozeman & Dent, P.A.  
734 Delmas Avenue  
Pascagoula, MS 39568

Dear Ann and Charles:

I am writing to you at Peter Biersteker's request regarding the available date for the deposition of Mr. Verner.

Mr. Verner is available to be deposed on March 22 in Chicago. As you are aware, Mr. Verner is no longer an employee of R.J. Reynolds Tobacco Company. Accordingly, to accomodate his schedule, this deposition must occur on a weekend day. In addition, please note that we plan to conduct a direct examination of Mr. Verner and to have this deposition video-taped for use at trial.

Please let me know at your earliest convenience if this date is compatible with your schedules.

Sincerely,

*Geoffrey K. Beach*  
Geoffrey K. Beach

*Verner*

*53*

*3-22-97*

51604 6223

LAW OFFICES  
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GREENVILLE, SOUTH CAROLINA  
RALEIGH, NORTH CAROLINA

February 26, 1997

VIA FACSIMILE (202) 943-5999

Murray R. Garnick, Esquire  
Arnold & Porter  
555 12th Street  
Washington, DC 20004-1202

Re: *Moore*

Dear Murray:

We accept the following dates which have been provided for the depositions of defense experts:

03/05/97	Beasley, Lynn
03/28/97	Carmichael, Benjamin M.
03/13/97	Carr, Lawrence A.
03/17/97	Ciraulo, Domenic A.
03/14/97	Dommel, Paul R.
03/20/97	Ellis, Cathy L.
03/31/97	George, William Jacob
03/12/97	Glenn, James F. (2 days)
03/14/97	Goff, David H.
03/28/97	Hamm, Jr., Thomas E.
03/21/97	Henke, Lucy L.
03/18/97	Houghton, Kenneth S.
03/03/97	Iauco, David N.
03/27/97	Knight, Charles
03/12/97	Leitzinger, Jeffrey
03/20/97	Long, Hugh W.
03/13/97	Lowery, James C. (Will)
03/21/97	Luckott, William S.
03/28/97	Ludemerer, Kenneth M. (2 days)
03/29/97	Lyell, Mark
03/07/97	McAllister, Harmon C. (2 days)
03/24/97	Millene, Terry J.

51604 6224

*Vanner* 54  
3-22-97

Murray R. Garnick, Esquire  
February 26, 1997  
Page 2

03/20/97	Mizerski, Richard G. (2 days)
04/29/97	
03/28/97	Morse, Edward V.
03/27/97	Robinson, John
03/12/97	Rowell, Peter P.
03/31/97	Rubin, Emanuel (2 days)
03/19/97	Scott, Bradsher T.
03/18/97	Semenik, Richard V.
03/14/97	Simmons, Billy
03/24/97	Simmons, William S.
03/11/97	Skates, John R.
03/18/97	Taylor, Malcolm P.
03/26/97	Thomas, Richard (2 days)
03/26/97	Townsend, David E.
03/28/97	Verhalen, Robert
03/22/97	Verner, Kevin
03/11/97	Viscusi, W. Kip (2 days)
03/12/97	
03/21/97	Wildes, Kevin Wm. (2 days)
03/27/97	Willey, Edward N.
03/31/97	Williams, Parham H., Jr. (2 days)
03/27-28	Worm, George

We have shown in parentheses those experts for whom we need two days. We also want two days each for Mark Montgomery and William Wecker, for whom we have not yet received dates of availability.

In addition, we would like to move Lawrence Carr and Peter Rowell to March 24 and 25, or to March 25 and 26, respectively. Please let me know as soon as possible whether these dates will be available.

Please do not hesitate to contact me if you have any questions.

Very truly yours,

*Ann K. Ritter/kw*

Ann Kimmel Ritter

AKR/kw

51604 6225

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WRITER'S DIRECT NUMBER:

(202) 879-3991

March 14, 1997

VIA OVERNIGHT SERVICE

Jodi W. Flowers, Esq.  
Ness, Motley, Loadholt,  
Richardson & Poole  
151 Meeting Street, Suite 600  
Charleston, SC 29402

Re: Moore - Verner Deposition

Dear Ms. Flowers:

This will confirm that you intend to take the videotaped deposition of Mr. Kevin Verner on March 22nd in Chicago, Illinois at the location and time indicated on the Notice of Deposition received March 13, 1997.

As I indicated to Ms. Hoffman, and previously on February 19th in a letter to Ms. Ritter, we anticipate conducting a brief video-taped direct examination of Mr. Verner following the conclusion of your deposition for use at trial. Ms. Hoffman told me that she would discuss this with you so that we can work out the necessary logistics. I am confident appropriate arrangements can be worked out, and appreciate your cooperation in that regard.

Enclosed are the documents which defendants have agreed to produce in connection with the depositions of defense experts. In addition, I have two short video tapes to be produced and a few other items. These additional items are being duplicated and will be forwarded under separate cover early next week, or sooner if possible.

Please do not hesitate to call if you have any questions.

Very truly yours,

*Geoffrey K. Beach*  
Geoffrey K. Beach

51604 6226

# Ness, Motley, Loadholt, Richardson & Poole

---

151 Meeting Street, Suite 600  
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---

## FAX TRANSMISSION COVER SHEET

---

Date: March 19, 1997  
To: Geoffrey K. Beach, Esquire  
Fax: (202) 737-2832  
Re: Verner Deposition  
Sender: Colleen Caron for Jodi Flowers  
Client No.: 053700  
The original ☐ will ☒ will not be mailed to you.

---

YOU SHOULD RECEIVE 2 PAGE(S), INCLUDING THIS COVER SHEET. IF  
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51604 6227

Verner 56  
3-22-97



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KALEIGH, NORTH CAROLINA

March 19, 1997

VIA FACSIMILE (202) 737-2832

Geoffrey K. Beach, Esquire  
Jones, Day, Reavis & Pogue  
1450 G Street, N.W.  
Washington, DC 20005-2088

Dear Geoffrey:

I write to address your request that the defense be allowed to take an hour-long direct video deposition during the March 22nd deposition of Mr. Verner. In light of the defense's position that Mr. Verner will not be brought to trial, after having had an opportunity to confer with other counsel for the State, we have decided we have no need to take a deposition of Mr. Verner, and are thus canceling his deposition. I would appreciate it if you would notify Mr. Verner and other defense counsel of this decision.

Please do not hesitate to contact me should you have any questions.

Yours very truly,

  
Jodi W. Flowers

JWF/crc

**DICTATED BUT NOT READ**

51604 6228

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## FAX TRANSMISSION COVER SHEET

Date: March 21, 1997  
To: Geoffrey K. Beach, Esquire  
Fax: (202) 737-2832  
Re: Kevin Verner Deposition Notice  
Sender: Colleen Caron, Legal Secretary to Jodi Flowers  
Client No.: 053700  
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3:22:97

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DALLAS, TEXAS

March 21, 1997

VIA FACSIMILE (202) 737-2032

Geoffrey K. Beach, Esquire  
Jones, Day, Reavis & Pogue  
1450 G Street, N.W.  
Washington, DC 20005-2088

RE: Kevin Verner Deposition Notice

Dear Geoffrey:

We received yesterday evening, Thursday, March 20, 1997, a Notice of Deposition for defense expert Kevin Verner to take place in Chicago on Saturday, March 22nd. Please be advised that the State is of the position that this Notice is insufficient and as such, we will not be able to attend this deposition.

If you have any questions, feel free to contact me.

Very truly yours,

Jodi W. Flowers

JWF/crc

**DICTATED BUT NOT READ**

51604 6230